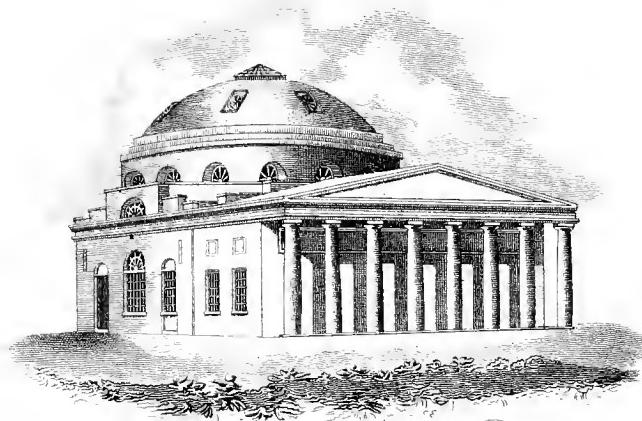




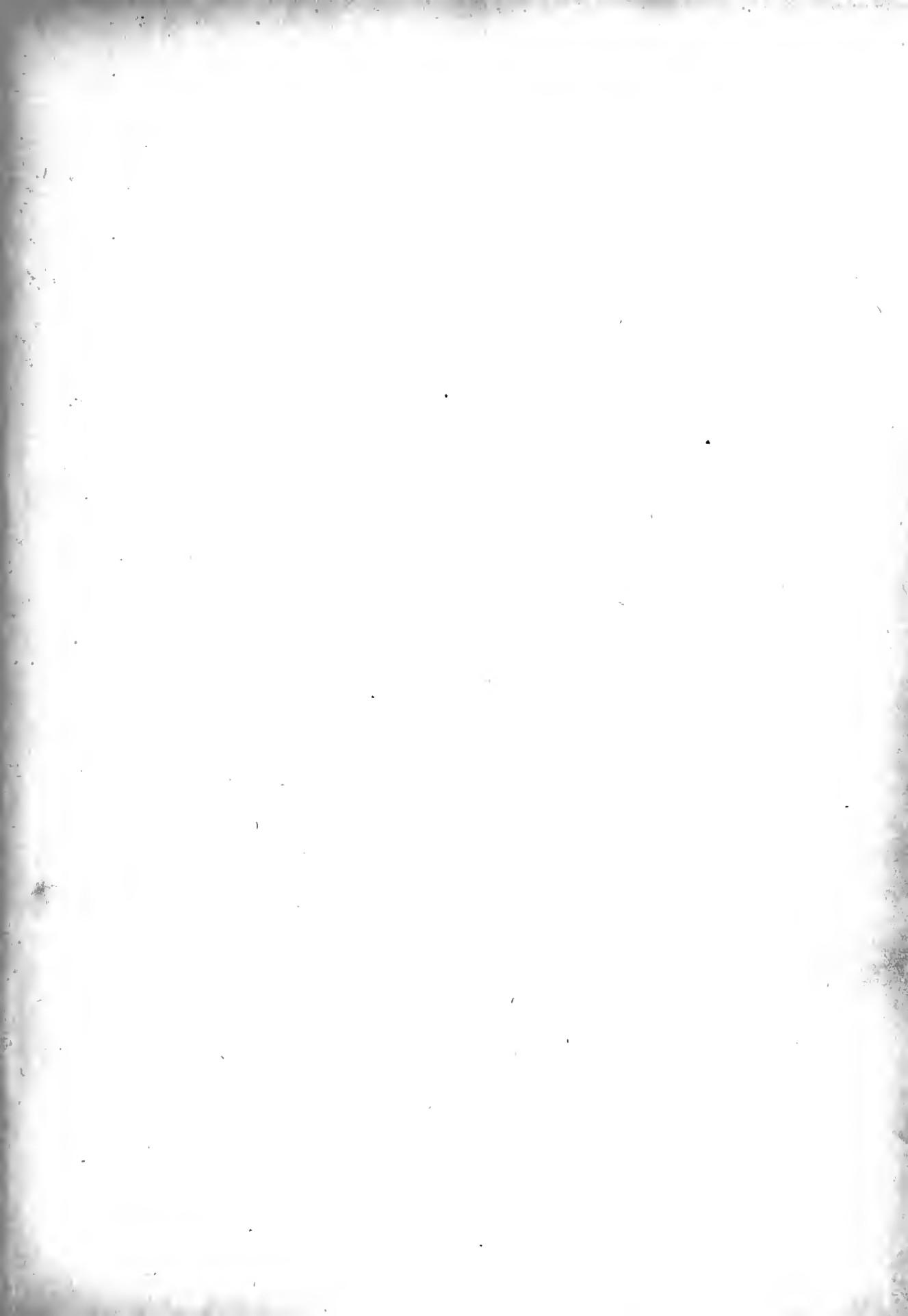
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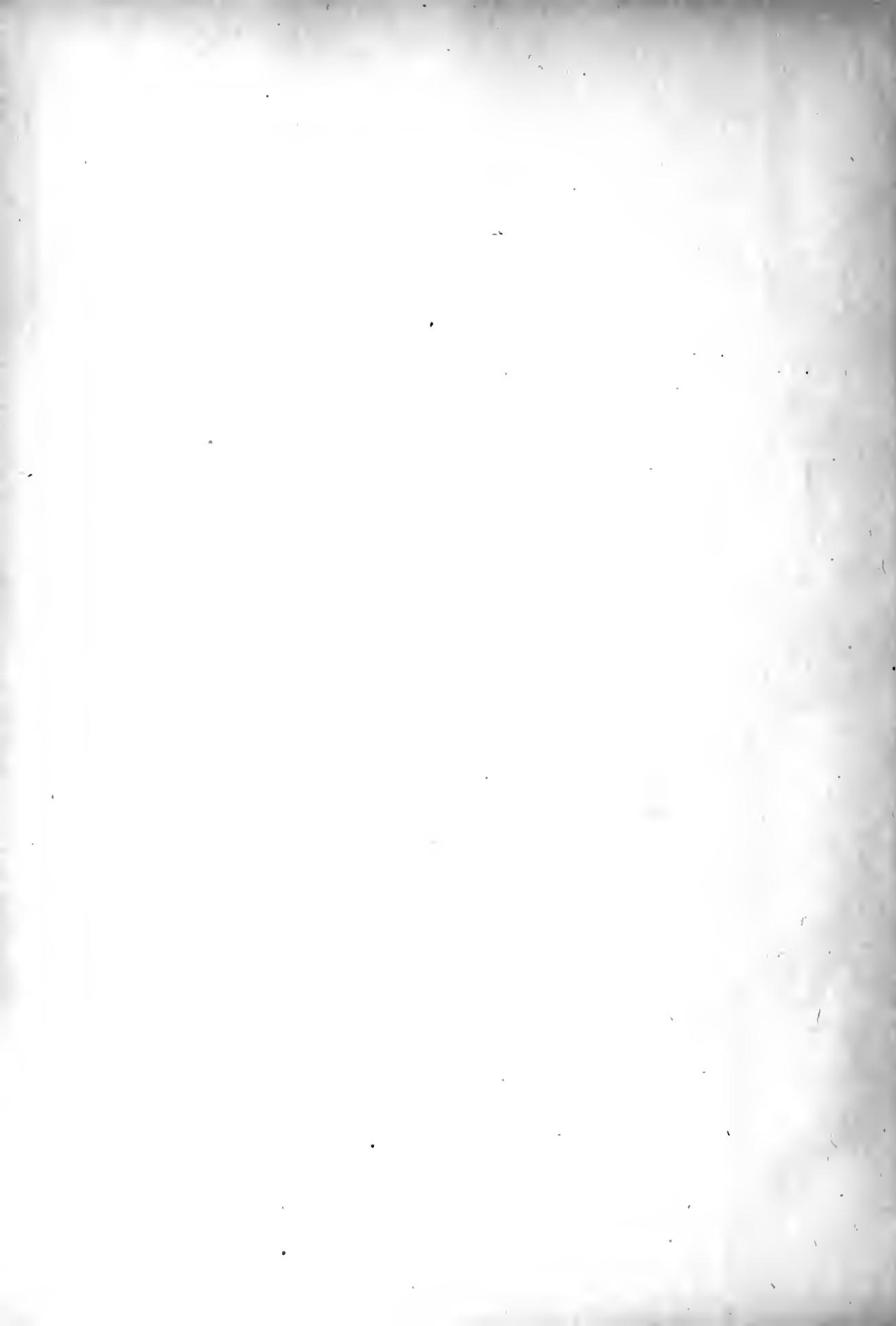


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# THE HOSPITAL BULLETIN

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No. 1

## GOITRE.

BY RANDOLPH WINSLOW, M.D., LL.D.

(Continued from Page 236, Vol. V, No. 12.)

*Thyroidectomy.*—The best incision for operations on the thyroid gland is the transverse or collar incision of Kocher, though in some cases it may be advisable to employ other methods of approach. This incision falls naturally into one of the folds of the skin of the neck and subsequently becomes almost invisible, a matter of much importance to women, and it may be entirely hidden by a collar or a ribbon around the neck. The incision divides the skin and platysma muscle, which are reflected upwards and downwards, exposing the deep cervical fascia, which is freely divided in a transverse direction; the ribbon muscles of the neck now come into view and are retracted, or, if necessary, divided near their insertions into the hyoid bone and larynx. The thyroid gland is now exposed, and the connective tissue capsule of the organ is incised and carefully separated from the gland with the fingers and blunt dissector, all vessels being carefully isolated and doubly clamped and subsequently ligated.

The thyroid lobe that is most enlarged is now dislocated from its bed in the neck and is drawn towards the opposite side; by means of gauze pads the capsule and connective tissue is still further wiped off from the lateral and posterior aspects of the gland, avoiding injury to the parathyroid bodies and the recurrent laryngeal nerve. The isthmus is now couched with strong forceps and ligated in the groove made by the crushing instrument, and the loose portion is cut off. All raw surfaces are covered with the redundant capsule, bleeding is carefully arrested, the wound flushed with normal salt solution, and free drainage established by means of one or more rubber or glass drainage tubes. The divided muscles are

reunited with catgut, the fascias sutured together again, the platysma sutured separately with catgut, and the skin with a subcutaneous wire strand. The drains are usually removed in 48 hours, and the wound closes in a short time. The patients are generally discharged in from seven to ten days.

*Enucleation.*—When an isolated cyst or solid mass is situated in the thyroid gland, it is not necessary to remove a whole lobe, but the mass may be enucleated, leaving the glandular tissue practically intact and avoiding the danger of injuring the parathyroids or of lessening the functional activity of the thyroid itself.

The gland is exposed in the usual manner and an incision is made through the overlying tissues until the sac or tumor is reached, when the mass is separated by blunt dissection. Often there is quite free hemorrhage, which can be controlled by pressure or by suturing the raw surfaces from which the bleeding occurs.

*Ligation of the Thyroid Vessels.*—In cases of vascular goitres, and notably in those of pulsating exophthalmos, or where the physical condition of the patient is bad, the ligation of the superior thyroid vessels is sometimes followed by a permanent cure, but more frequently by such an improvement in the local and physical status that a partial thyroidectomy becomes safe and proper. On the other hand, when the symptoms of Graves' disease still persist after the removal of one-half of the gland, the ligation of the opposite superior thyroid vessels is often followed by very beneficial effect.

The operation is easily done by means of a transverse incision crossing the thyroid cartilage about its middle, the vessels are superficially placed and are readily found.

I have operated on the thyroid gland for goitre in some of its various forms 30 times, with 29 recoveries and one death. The fatal result was from acute thyroidism, possibly from too much manipu-

lation of the gland. Four of these operations were on males, 26 on females. Three only were on colored persons, the rest were white of divers nationalities. Three were marked cases of Graves' disease and two others presented symptoms of hyperthyroidism, but had probably not reached the stage of Graves' disease.

In most of these cases I removed one lobe and the isthmus. Sometimes I also excised a portion of the remaining lobe. In a few cases I was able to enucleate isolated nodules, leaving the gland intact, as originally recommended by Socin. In some cases I have been able to operate within the capsule even before the subcapsular method of Charles H. Mayo was announced. I have usually attempted to secure the arteries, especially the inferior thyroid, after its distribution to the capsule of the gland, in order to avoid danger of injuring the recurrent laryngeal nerve. I do not know of any cases of tetany or myxedema occurring in those upon whom I have operated. I endeavor to avoid removal of the parathyroid glands, and I always leave a portion of the thyroid *in situ* to guard against myxedema.

Whilst all enlargements of the thyroid gland are disfiguring to the patient and a source of mortification, but few of them remain any length of time without producing symptoms either by pressure on the trachea, esophagus and vessels or by causing constitutional reaction from an increase or diminution of alteration in the secretion of the gland; hence goitres of all varieties should be dealt with as surgical maladies at an early rather than a late period. This is emphasized further by the fact that malignant changes occur in a considerable percentage of cases, and the only possible hope of forestalling or curing these cases lies in an early operation.

I append herewith short histories of the cases of goitre upon which I have operated:

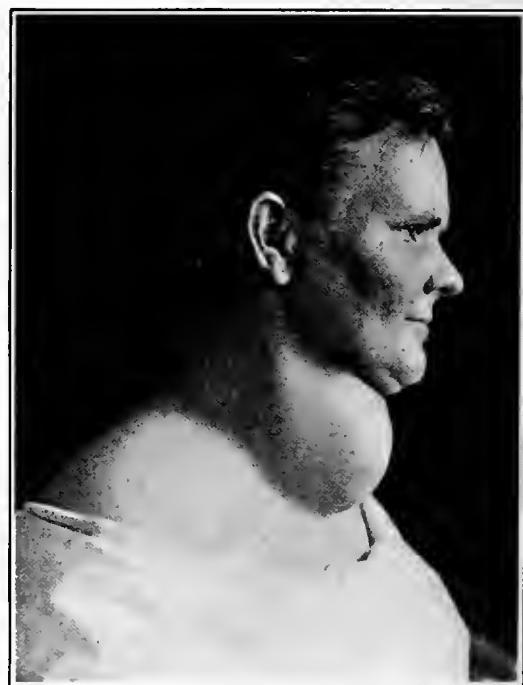
#### CASE I.—*Cystic Goitre (Cured).*

Mrs. D., aged 38 years, was first treated at the Presbyterian Eye, Ear and Throat Hospital for a large cystic goitre, injections of 10 per cent. iodoform emulsion being given. As the growth continued to increase in size, she was referred to me by Dr. John R. Winslow, and was admitted to the University Hospital on June 27, 1900.

She comes from a family of great longevity, her maternal grandfather having died at the age

of 93 years and her maternal grandmother being still living and 90 years old. There is nothing material in her family history or in her past history. She has had three children and two miscarriages, the last being about 12 years ago.

The present trouble commenced 10 years ago and has continuously gotten larger. The growth is situated over the trachea and extends from the larynx to the sternum. It is resilient and evidently contains fluid. It rises and falls during deglutition and is painless and not adherent to the overlying skin. It causes an impediment to respiration unless she carries her head well up and



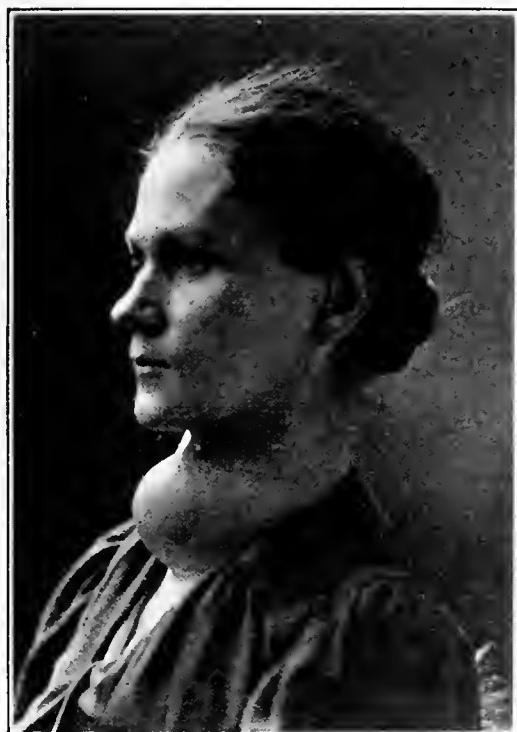
CASE I.

back, and there is some interference with deglutition. The voice is somewhat altered. As the patient was incommoded to such an extend as to render her unable to attend to her household duties, I advised extirpation of the tumor, which was done on July 2, 1900.

A curved flap was made at the root of the neck and the goitre exposed. The tumor was cystic and limited to the right half of the gland. The left half of the thyroid was left *in situ*. There was perhaps a pint of colloid fluid in the cyst. Ether was first given and then chloroform substituted, in order to lessen the congestion of the neck. She made an uninterrupted recovery.

CASE 2.—*Adeno-Cystic Goitre (Cured).*

C. W., aged 27, was admitted to University Hospital on December 28, 1900. Her mother died at 34 years of age from the effects of a large goitre; otherwise her family history is negative. An enlargement of her neck was first noticed when she was three years old and has been increasing ever since. It now measures 16 inches in circumference, and interferes with respiration unless she holds her head well back. It does not interfere with deglutition. Her voice is slightly altered. The growth is hard, and is especially prominent over the trachea, but also extends under each sterno-cleido-mastoid muscle.



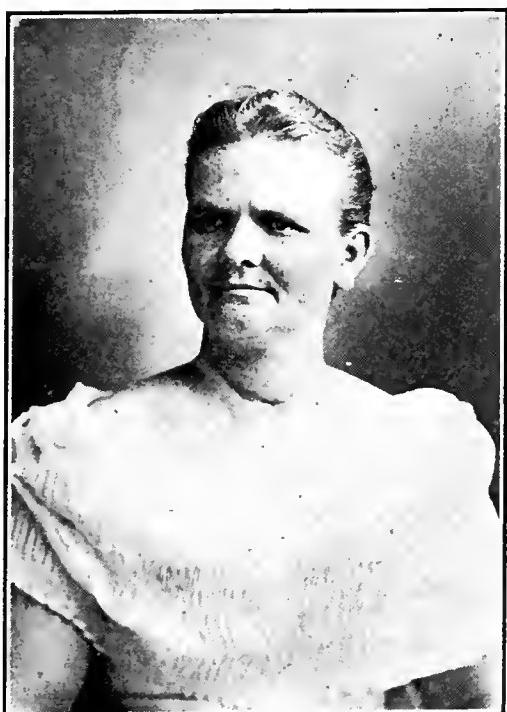
CASE II.

semi-reclining position. She was kept on a liquid diet for a week. There was quite sharp reaction following the operation, the temperature reaching as high as 103°. She made a good recovery.

CASE 3.—*Colloid and Hemorrhagic Goitre (Cured).*

Mrs. R. E. M., admitted July 14, 1902; discharged July 28, 1902; white; aged 37; housewife.

About six years ago patient noticed a slight enlargement of the right side of the neck, which gradually became larger until the present time.



CASE III.

Under ether anesthetic a curved incision was made at the root of the neck and the gland exposed. The tumor was very vascular and had numerous large veins coursing over it. The thyroid vessels were ligated at each angle of the growth, but the operation was quite a bloody one. A portion of the left lobe left in order to supply thyroid tissue to the system. The tumor consisted of adenomatous growths, with numerous cysts of variable size. The patient suffered considerably for 36 hours and had to be kept in a

It has never caused her any pain, nor has she ever noticed any redness or inflammation. She has never noticed any decided pulsation at that point, nor has it led to any disagreeable symptoms other than the disfigurement. The tumor feels rather firm on pressure and is about the size of a lemon. When it started it did not feel like a distinct lump, and does not now. Patient has not become at all emaciated, has no cough, and is not particularly susceptible to catarrh. Appetite is not good. An incision of six inches was made on the right side

of the neck, extending from the inferior border of the lower jaw to the upper border of the sternum, and a tumor of about the size of a small orange, firm, but containing no fluid, was removed from the right side of the neck. Wound was entirely closed and patient did well. A microscopic examination of the tumor showed it to be a colloid and hemorrhagic goitre. A general anesthetic was used in this case.

CASE 4.—*Cystic Goitre (Cured).*

C. D., admitted January 2, 1903; discharged January 12, 1903; 18 years old; white; house-work; single. Patient has been in this country



CASE IV.

for two years, which is about the time she has noticed the growth in her neck. It was of small size, but gradually became larger and larger, until the growth reached the size of a hen's egg. Patient was treated by Dr. Hirsh about eight months ago, but showed no improvement, so was advised by him to come to the hospital to be operated upon. The growth never caused the patient any trouble, pain or discomfort. The patient was operated upon January 3, after the usual preparations. An elliptical incision about five

inches long and extending from the right side to the left was made and the tumor dissected out. It was pushed easily from its sac, and was found to be cystic in character and to contain about five ounces of fluid. The wound was closed by a subcutaneous suture. The patient before the operation had pulse about 130, and it was said by Dr. Hirsh that her pulse seldom ever fell below 120, but at present it is 90. Patient made a good recovery; ether anesthesia.

(To be continued.)

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THE TRAINING OF MEDICAL STUDENTS FOR OBSERVATION AND RECORDING OF CLINICAL CASES—THE REASONING-OUT OF THE DIAGNOSIS FROM THE FACTS OBSERVED AND STUDIED BY THE STUDENT HIMSELF—HOW TO EXPLAIN AND INTEREST SIGNS AND SYMPTOMS AND TO FORMULATE THEM INTO CLINICAL CONCEPTIONS.

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By JOHN C. HEMMETER, Ph.D., LL.D.,  
*Professor in the University of Maryland,*  
and

ALBERT CARROLL, M.D., and L.C. LABARRE, M.D.,  
*Clinical Instructors.*

---

In teaching medical students to become practitioners of ability two factors are of paramount importance: First, the personality of the teacher; second, the amount and character of the clinical material. The teachers must be good, the material must be varied and abundant. There can be no doubt what is meant by abundant and varied material; but concerning what is meant by a good teacher of medicine there is considerable difference of opinion. I do not intend to go into a definition of a good teacher, but rather to show in an indirect way how the effects of good teaching will show on the student. During a long experience in observing the methods of clinical teaching in this country and in Europe, the principal methods of imparting a knowledge of clinical medicine are as follows: First, direct the student personally as to what is expected of him and how he is to go about it.

Second, do the work for him and let him observe you doing it.

Third, lead him to practice it under your own direction until

Fourth, he is capable of doing it himself under your personal supervision.

These four methods embrace, each one of them, the three processes of gaining clinical knowledge, namely: (1) Observation. (2) Recording what has been observed. (3) Interpreting the recorded data.

The first thing the student has to learn is how to observe and study the patient. Then he must become practiced in making precise records of all his facts, and, thirdly, he must learn to reason with these recorded clinical data. In order to acquire this ability, clinical introductory lectures cannot be dispensed with. Whenever a new subject or a new method is taken up, or whenever a patient that illustrates a new condition presents himself, then the teacher should be ready to explain how that particular method, subject or patient is to be studied. The teacher should, if possible, furnish the student with a schedule or schema which he may use himself in the out-patient department whenever the teacher is not present. It is also necessary that the amount and kind of work to be devoted to each subject, each method and each patient should be described by the teacher, as well as the correlation and dovetailing of the subject and methods that may have to be taught by different instructors and professors.

Some professors of medicine, like Dr. C. S. Minot, would like to do away with lectures altogether (See his address at the Yale medical commencement, published in *Science*, July 7, 1899), but to me it seems impossible to dispense with the lecture absolutely in clinical teaching, especially where the ground plan of the whole course has to be gone over, and where the correlation and dovetailing of subjects has to be explained. Such things cannot be demonstrated nor practiced by the student; they must be explained by the teacher.

After such a clinical lecture, which should not exceed 40 minutes, the student should be encouraged to ask questions.

#### LARGE AMPHITHEATER CLINICS.

As Dr. S. Weir Mitchell has correctly said, the best lecturing does not so much think for you as invite you to think along suggested lines of inquiry. Therefore, in the large amphitheater clinic there should be not so much lecturing, but it

should be utilized mainly to get the following purposes:

First—Teaching the student how to get a subjective and objective history from the patient by a kindly, thorough, yet tactful questioning. Yes, the student should even be led to attribute importance to listening with consideration to the complaints the patient has to make, provided they are not spun out too long, which is especially the case with such as are not very sick. Then, as the teacher percusses, auscultates, palpates and inspects, he should not presume too much of an already-existing knowledge of these methods in the student.

Second—The exemplifying *good record keeping* is an important lesson for the large clinic, for it is in my experience impossible for the student to learn record keeping without any previous acquaintance with good models. After that comes the personal practice in accordance with the observed models.

Third—The large clinic is the proper place for the demonstration of all technique, whether purely manual or instrumental. The technique of the clinical laboratory is only in rare instances to be transferred or repeated in the clinic. It is generally presupposed in the listener of a clinic.

Fourth—*Interpretation and reasoning from records supposed to be correct.* There are two ways of gaining information concerning the nature of human illness and its management. One is from a personal and direct study of the sick individual himself or herself. Naturally, this way of study depends upon the actual cases that happen to be available, and as these vary greatly in quality and quantity, we are likely to get a heterogeneous group of diseases and an unsystematic and haphazard manner of teaching. The second way is to substitute the study of hospital records of cases to take the place of the examination of the cases themselves. This has been somewhat inappropriately termed the *case method*, and is much used in law schools. It was found possible to group cases so that they would throw light upon each other and a more consecutive and consequential study of human diseases could be arranged. Nevertheless, this method has its defects also. The student is too apt to permit the record to think for himself. He misses the stimulus of contact with the actual patient, and he reads the record as he would a book.

METHOD PURSUED AT THE CLINIC FOR DISEASES OF  
DIGESTION AND METABOLISM IN THE  
UNIVERSITY OF MARYLAND.

There is nothing strikingly new about our system, except that we use both the first and the second of these methods together; that is, the student does personally study the patient and examine him, but he also studies already-existing records with a view to finding as near as possible a parallel case. But the studying of the patient by the student himself is not done at the clinic. It is done in the out-patient department during the week preceding the clinic. For every week four students are appointed from the graduating class to observe, take the record and interpret a given patient. They must do all the percussing, auscultating and palpating under the supervision of the associate professor; they must make all chemical and microscopical examinations. They carry out all instrumental inspections under the direction of the instructor. When the clinic comes, two students present themselves to the entire class (generally over 100 students); they demonstrate what is of importance on the person of their patient—the urine, gastric contents, the blood, the sputum, the feces, if necessary and important; also, if necessary, the spinal fluid. The student also demonstrates the patient's reflexes in case they have a bearing upon the actual morbid state. In all gastric and intestinal cases the condition of the heart, lungs, liver, kidneys, spleen and genitourinary organs is as thoroughly gone into as if each of these alone were suspected of being the cause of the illness.

When all the recorded data are read and the most important facts demonstrated on the patient's person, the student draws his conclusions, states the diagnosis and outlines the treatment. During this time the professor remains seated quietly, taking an active interest in the proceedings, but saying nothing until the case has been fully presented, unless some gross misunderstanding is taking place which would frustrate the usefulness of the entire procedure. This however, in my experience, very rarely occurs, if the cases have been properly prepared. After the cases have been presented in this manner, four other students are requested to leave their seats to test the salient points in the diagnosis on the patient. Can they confirm the conclusions reached? Is any other diagnosis possible? Do they remem-

ber ever having seen a similar case? In what manner did they resemble each other, or did they differ? Do they know of any records which remind them of this present case. After this conference is over, the professor praises or criticises, as the case may be. As a rule, it is wise to be slow and tactful with criticism, and where it must be bestowed it had best be mingled with a little praise, even where an error has been made. Generally it is perfectly justifiable to praise the interest and diligence, even if an erroneous conclusion is evident. Criticism must be constructive, not destructive. In this way we generally succeed in having three or four cases presented at every clinic, and the student is cautioned to be sure to visit this patient at his or her home should the patient agree to it, and present the case again at a future clinic in order to demonstrate the effects of the treatment.

Some very able clinical teachers combine with clinical teaching a certain amount of instruction concerning the methods of looking up a subject, on reading and bibliography. Important and beautiful as this would be, I have found it not feasible in the large amphitheater clinic. As Dr. Richard C. Cabot correctly says, learning medicine is not fundamentally different from learning anything else. If one had 100 hours in which to learn to ride a horse, or speak in public, one might profitably spend an hour or two in being told how to do it; four hours in watching a teacher do it, and the remaining 95 hours in practice, at first under close supervision and later under general oversight. The case is not very different with medical education. Taking 100 as a standard number of hours allotted to the study of clinical medicine, the student should be talked to about what he is to do and about whatever new piece of work lie is about next to attack for about 1 per cent. of his time. If his teacher is a good model in the process of record-taking, observation and interpretation, he should watch his teacher for about 25 per cent. of his time; but for about 75 per cent. of his time he should practice all those procedures in which he must become proficient to make a skilful and reliable physician. All these procedures I have dwelt on in the preceding. They embrace all the technical manipulations used in clinical diagnosis, the history-taking, and the methods of making deductions and reasoning out the diagnosis. Not least among these

is the practice of learning how to converse with patients to inspire them with confidence by the firm yet tactful manner of questioning them. The student must learn the art of penetrating into the subconscious as well as the conscious life of a patient. Even the large amphitheater clinic can be used to training students in this manner. In the following I shall present a synopsis of clinical records embodying all the factors mentioned above and taken by the following members of the class of 1910, candidates of medicine:

G. M. Brewer, Thomas Brooks, Wm. Gray Brooks, J. H. Von Dreele, Jr., George S. Condit, Michael S. Hanna, H. M. Foster, R. L. Kennedy, C. N. DeVilbiss, A. C. McCall and M. L. Cahn.

These clinical histories do not illustrate the full extent of the lesson at the clinics, nor do they give the discussion at the end of the clinics, nor the reciprocal cross-examination and questioning between the professor and the student. It is evident that this would lead too far, and unnecessarily increase the size of this publication, inasmuch as it would inevitably contain much repetition. The rubber stamp of the thoracic and abdominal cavity shows the measurements that are taken on each patient's body. By taking a great many measurements on normal and diseased individuals my students have aided me in confirming the opinion of life-insurance examiners that an individual of a certain age, height and weight must have definite measurements and dimensions of his thoracic and abdominal cavity. It has also been learned that when these measurements are under a certain given standard established for the age, height and weight, the patient as a rule has enteroptosis. The abbreviations are explained in the following:

M-X means the distance from the manubrium to the xiphoid cartilage.

M-U means the distance from the manubrium to the umbilicus.

M-S means the distance from the manubrium to the symphysis.

X-R-S means the distance from the xiphoid to the right superspine ileum.

X-L-S means the distance from the xiphoid to the left superspine ileum.

S-S means the distance from right superspine to left superspine ileum.

C at X means the circumference at the xiphoid.

A to X means the distance from the atlas to the promontory of the sacrum.

X-angle means the angle below the xiphoid. (This is taken with a graded sector.)

Important instruction was given in the use of X-ray photography as a means of diagnosis in diseases of digestion. Two cases of carcinoma and three cases of ulcer of the stomach were diagnosed in this manner in December, 1909, and January, 1910. The X-rays were made use of for the diagnosis of conditions of the stomach first by Hemmeter in 1896 (see "Photography of the Human Stomach by the Röntgen Rays." *Boston Medical and Surgical Journal*, June 18, page 609, 1896). The special technique for diagnosing gastric ulcer and carcinoma by the X-rays was later perfected by Dr. Hemmeter and published in Berlin in the *Archiv für Verdauungskrankheiten*, Vol. XII, page 357 ("New Methods for the Diagnosis of Gastric Ulcer," etc.). The negatives as well as the prints were exhibited in the clinic, together with the patient. In three enteroptosis cases an X-ray photo of the thorax and abdomen, also taken at the University Hospital by Dr. Howard E. Ashbury, demonstrated the fact that these patients had also displaced hearts ("corpendulum"), in addition to displaced stomachs, kidneys and prolapsed transverse colon.

The following clinical histories are not all as complete as they were presented. The discussion had to be omitted for lack of space.

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#### REPORT OF TWO CASES OF TRANSFUSION OF BLOOD, OCCURRING AT THE HEBREW HOSPITAL.

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By CHARLES BAGLEY, JR., M.D.,\*  
*Medical Superintendent.*

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I wish to call attention of this society to two cases in which transfusion of blood was resorted to by Dr. Spruill and myself during the past month. I will make no attempt to outline the medical treatment of these cases, the first one having been in the service of Drs. Hirsh and Amberg, and the second in that of Dr. Adler for some time before they were referred to the surgical service.

CASE No. 1.—A. R.; female; age 7.

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\*Read before Clinical Society of the University of Maryland, January 17, 1910.

*Diagnosis*—Chronic parenchymatous nephritis. Admitted to the hospital on September 23, 1909, and presented a course which is usually found in this condition, slight temperature being noted until December 20, when there was a sudden rise from normal to 101.6°. There was also an increase in the pulse rate, and the patient was drowsy and very uncomfortable. This condition continued until the afternoon of December 22, when Dr. Amberg requested that the patient be transfused. Arrangements were immediately made, which consisted of the securing of the donor and the examination of the blood of the donor and the recipient, and the estimation of the blood pressure of both. We were fortunate in securing the mother as the donor, the sentiment of a member of the family being of great assistance in the management of both patients. This is also beneficial on account of the close similarity of the blood, although any human blood may be used.

The donor was healthy, well developed, and with a good history. The tuberculin and Wasserman tests were not made, first, because there was no evidence of either tuberculosis or syphilis, and second, as time could not be taken for these procedures. The haemolytic test was also omitted, first, on account of time, this test requiring 24 hours (I am quite sure this test will often have to be omitted, as transfusion is usually called for in emergency cases), and, second, because of the close relation between the mother and the child, which would lessen the danger of haemolysis. The red blood count of the donor was 4,320,000; the haemoglobin, 74 per cent. The blood pressure was 165. It was then decided to accept this donor and she was placed in bed in the ward and given a hypodermic of  $\frac{1}{6}$  of morphia at 4 P. M.

The blood count of the patient was then carefully made and the red corpuscles found to be 2,760,000, white corpuscles 21,000, haemoglobin 32%; coagulation time,  $3\frac{1}{2}$  minutes; blood pressure, 135.

Two adjoining operating-rooms were then made ready and the donor removed to one, where necessary instruments were placed for the dissection of the right radial artery, under cocaine; and the recipient to the other, where similar instruments for dissection of the right basilic vein and for the anastomosis of the vessels were placed. The right radial artery of the donor was dissected by Dr. Spruill, about two inches being freed from

all surrounding tissue; all side vessels being carefully tied off with fine silk and all bleeding in the surrounding tissue carefully controlled. A Crile's clamp was then carefully screwed upon the proximal side of the artery close to the undissected portion. The lower portion was clamped and a ligature firmly placed upon the end, after severing the vessel, thus leaving between  $1\frac{1}{2}$  to 2 inches of free vessel on the proximal side with which to make the anastomosis. As soon as the artery was exposed a small current of warm normal salt solution (100° F.) was allowed to flow over the vessel in order to encourage good circulation.

While this was being done, the right basilic vein of the recipient was dissected in the same manner, a Crile's clamp again being screwed upon the proximal end of the vessel, while the distal end was left open in order to remove a certain amount of blood. This vein was opened at 5 P. M. and the blood allowed to flow until 5.41, a period of 41 minutes. The blood pressure of the recipient at the beginning of the blood-letting was 135 and when it was discontinued the blood pressure was 108. This was done in order to diminish the toxæmia of the patient and lower the pressure.

As the vessels were now ready for the anastomosis, the donor was taken into the room where the recipient had been prepared and placed with her head toward the feet of the recipient, thus allowing the right arm of the donor to be easily placed beside the right arm of the recipient. A No. 2 Crile's canula was then selected and firmly grasped in an artery clamp. Three fine silk sutures were placed in the end of the severed radial artery at equal distances from each other. The loops were then threaded through the canula and the same pushed upward along the artery until about 12 mm. of the vessel protruded through the canula. While the canula was firmly held by an assistant, the end of the artery was pulled backward over the canula by means of the silk ligatures previously spoken of, and a ligature passed around the vessel and tied firmly in the groove nearest the handle. The outer surface of the portion of the vessel now covering the canula is, of course, the endothelial lining of the vessel. This was thoroughly lubricated with liquid vaseline in order to have the vein glide over it without friction. Three silk sutures were then placed in the end of the vein, which were used as traction sutures to draw the open mouth of the vessel

over the endothelial-covered canula, thus making a continual endothelial surface over which the blood was to flow. A ligature was then tied around the vessel, the Crile clamp removed from the venous side, and immediately afterwards the one from the arterial side was removed. It was then found that the blood was not flowing into the vein, and it was decided to disconnect in order to locate the trouble. In attempting to remove the ligature which had been placed around the vein it was found that in tying the same it had been allowed to slip over the canula, and this constricted the artery. Great care must be taken in every case to prevent this if the Crile's canula is to be used. This was removed and a ligature applied in its proper place around the second groove of the canula, when the blood was found to flow without difficulty. When the anastomosis was completed, a distinct pulse could be detected in the vein of the recipient. The blood pressure of the donor was now 160 and that of the recipient 108. The blood was allowed to flow continuously until 6.35 (a period of 20 minutes), when the blood pressure of the donor was 142 and that of the recipient 128, 7 points less than the pressure before bleeding. A warm solution of normal salt was allowed to flow over the vessels during the entire time, thus avoiding a clot. The normal salt solution is very important and requires one assistant to care for this only. Clamps were then placed upon the vessels near their undissected portion and a ligature applied around each. The wounds were sutured with subcutaneous cat-gut suture, the subcutaneous suture being used as less pain is experienced in passing sutures in the subcutaneous tissue than in passing them through the skin. The pulse of the recipient at the beginning was 92; that of the donor was 120. At the completion of the operation the recipient's pulse was 92 and the donor's 88.

The following morning the temperature had fallen to 70. The temperature arose again in three days to 100.8°, but soon returned to normal, and there remained until the time of death on January 5, 1910 (14 days after transfusion). There was a decided improvement in the child's condition after the operation, but this seemed to be only temporary. We are unable to state the improvement in the output of urine, as a large quantity was lost and accurate measurements could not be kept.

At autopsy a bilateral broncho-pneumonia was found, which in all probability was the immediate cause of death.

CASE No. 2.—A. A.; male; age 40; cigarmaker.  
*Diagnosis*—Duodenal ulcer.

Admitted to hospital January 13, 1910, and presented a very interesting picture, which will be reported in full by Dr. Adler at a later date. I will simply state that several hemorrhages from the bowel occurred from the time of admission until nine days later, when he was transfused. At the time transfusion was decided upon the haemoglobin was 50%; red blood corpuscles, 2,630,000; coagulation time, 4 minutes; blood pressure, 185; the patient having marked arteriosclerosis and a valvular heart lesion. The daughter, a well-developed individual, 19 years of age, was selected as the donor. Her red count was 4,000,000; haemoglobin, 85%. Upon inquiring into her history, nothing was found to prohibit the use of her blood except the fact that she was menstruating. This objection was overruled, as the patient had been in the country but a short time and had very few friends from which to select a donor.

The patients were then removed to the operating-room, both being placed in the same room, thus avoiding the time and trouble of preparing two rooms. The vessels were dissected out in the same manner. The radial artery, appearing rather small, was cuffed the same as in the preceding case without difficulty. The vessels were anastomosed in the same way, one hour being required from the time the dissection was commenced until the anastomosis was completed. The blood was allowed to flow through the vessels from 5.30 until 6.08 (a period of 38 minutes). During this time a very strong pulse could be felt in the recipient's vein just above the canula. The blood pressure of the donor at the beginning was 140 and gradually fell to 120 within 17 minutes after the beginning. Until this time very little change could be noted in the donor, the pulse rate remaining about the same and only a slight paleness of the lips observed. At 6.07 (20 minutes later), during which time the blood was continually flowing, the recipient complained of headache, while the donor was greatly distressed with quickened pulse, dilated pupils and marked pallor. It was then found that her blood pressure had suddenly fallen to 70, which point was

just one-half the pressure registered at the beginning. The vessels were immediately clamped and the wounds were hurriedly closed, the entire procedure being completed in two hours. The donor was then found to be shocked, but quickly responded to an infusion of normal salt, a hypodermic of 10 min. of Tr. of Digitalis, with lowering of the head. The patients were returned to the ward in good condition.

After the transfusion the blood count of the donor was 3,600,000; haemoglobin, 68%—a diminution of 400,000 red blood corpuscles and 17% haemoglobin. On the following day it was found that the haemoglobin and red corpuscles had continued to fall, the former registering four points less and the latter 200,000 less than the day previous, and today (January 17, 1910), six the red blood corpuscles 3,740,000, the former showing an increase of 2% and the latter of 140,000 since the completion of the operation.

After the transfusion the blood count of the recipient was 3,670,000, haemoglobin 63%—an increase of 1,040,000 red blood corpuscles and 13% haemoglobin, and today (January 17, 1910) the red blood corpuscles register 3,900,000 and the haemoglobin 70%, and I am glad to state that there has been no recurrence of the hemorrhage from the ulcer.

This work has been done along the lines recommended by Dr. George W. Crile, and I will make no effort to discuss the subject of transfusion, as this can be found in detail, both from the experimental and clinical standpoint, in his book published during the past year. After a great deal of experimental work, Dr. Crile tried transfusion on a series of cases of the following diseases, and gives his results as follows:

*Useless.*

Pernicious anemia (later stage).

Leukaemia.

Carcinoma.

Exophthalmic goitre.

*Doubtful.*

Pernicious Anemia (early stage).

Leukaemia.

Sarcoma.

Tuberculosis.

*Good Result.*

Chronic suppuration.

Shock and collapse.

Hemorrhage.

Illuminating-gas poisoning.

He also used it in the following isolated cases:

Suppression of urine after pan-hysterectomy; failure.

Puerperal eclampsia (one case); recovery.

Superficial burns; recovery.

Pellagra (from patient who had recovered from pellagra); recovery.

Extensive burns; death.

The above cases clearly bear out the statement of Dr. Crile that the procedure is, perhaps, a specific treatment in cases of hemorrhage and allied conditions, but offers very little in cases of uremia, drug poisoning, etc.

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### CLINICAL HISTORY OF A CASE OF EROSION OF THE STOMACH AND HYPERCHLORHYDRIA.

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*Reported by M. L. Cahn for Prof. Hemmeter, M.D., Ph.D., etc., University of Maryland, Clinic on Diseases of Digestion.*

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Mr. A. R.; address, 8 Hazel street, Curtis Bay; white man, 34 years old; married; occupation, machinist.

*Diagnosis.*—Hyperchlorhydria, with a diagnosis of probable gastric ulcer.

*Family History.*—Father died at the age of 72; mother died at the age of 85; one sister dead, cause unknown; one sister alive and well.

*Past History.*—Negative as to infectious diseases; had gonorrhea and bubo; was treated for these diseases, and has had no recurrence. Patient uses alcohol moderately, on the average of about five or six glasses of beer daily; tobacco also moderately. Patient was injured about 10 years ago; both middle and ring fingers were treated, but it left the fingers deformed. About five months ago patient was injured on the scalp, was treated, and the injury soon healed.

About seven years ago, while working very hard, patient became dry; he then drank a pint of beer, and was immediately taken with a shaking chill, but was soon relieved by a physician; then, from the same cause, he developed a similar condition about three years ago, and also last spring, but was treated, and the symptoms disappeared. Patient always complained of constipa-

tion. He never had dysentery, typhoid or any abdominal diseases.

*Present History.*—Began about two weeks ago, while going to work (patient works at night). He drank a glass of beer. Patient began to work at 6 o'clock, and about 10 o'clock patient noticed sour eructations and felt bad, and then developed pains, which were sharp in character. These pains, according to the patient, radiated from the epi-gastrium upward to the lower part of the chest and over lower portion of the abdomen. The patient finished work that night and felt bad during the day, and went to work the following evening, but the pains became so severe that he had to stop work. These pains have continued until the present time at irregular intervals.

*Subjective Symptoms.*—These pains may be present at irregular intervals during the day, but are most marked after eating, especially at night. Patient will eat his supper at 6.30, and soon after eating these pains will come on, and about 9 o'clock patient will go to bed, and he is very restless. He often tosses about for several hours, and finally the patient will vomit, which often relieves him; then he falls asleep. On arising in the morning the patient complains of nausea and a dry taste in the mouth, which, he says, is more or less constant during the day. Patient also complains of stomach being constantly distended with gas and a sense of fullness and pressure in this region. Appetite poor, constant thirst and sour taste and eructation of gas, which is not continuous, and occurs either on an empty or full stomach. According to the patient, he has vomited about 10 times during the two weeks of illness, and the color of the vomit at first was greenish; later the vomited material was more or less of liquid in character and yellow or slightly brown in color.

*Physical Examination.*—General nutrition is good; no loss of weight. On inspection of face, expression of face slightly anxious; hair dark brown; eyes equal, react to light and accommodation; nose normal; teeth in good condition; tongue clean, reddish in color, protruding in the middle line; ears normal; no scars.

*Inspection of Neck.*—Showed no scars of glandular enlargements.

*Inspection of Chest.*—Expansion equal on both sides; no eruptions on chest; prominence of sternum, and also at the junction of the costal cartilages with the ribs. Chest is somewhat elongated; xiphoid angle appears wide.

*Inspection of Abdomen.*—No eruptions; no scars; no enlargements; no visible peristalsis.

*Inspection of Back.*—Shoulders rounded; projection of the scapula; has eruption on back which, according to the patient, has been there since childhood.

*Palpation.*—Skin slightly loose; on chest tactile fremitus normal; apex beat palpable normally; no thrills.

*On Abdomen.*—No enlargements or tumor masses; spleen not palpable; kidneys not palpable; has a sensitive area on the epigastrium by palpation.

*Percussion—Chest.*—Lungs normal; no areas of dullness; cardiac dullness normal; liver dullness normal. Percussion of stomach normal, not dilated; the cardiac is about the middle of the fifth or sixth rib; fundus in left hypochondrium, and rest in the epigastrium; the greater curvature of stomach is about two fingers' breadth above the umbilicus. On percussion in the epigastrium, the patient showed a localized area of tenderness. This was later verified by X-ray photography.

*Auscultation—Chest.*—Negative; no murmurs present; lungs normal; vesicular respiration throughout; fremitus normal.

*Heart.*—Apex beat good; mitral and tricuspid areas normal; pulmonic and aortic areas normal; the heart sounds appeared distant; no heart murmurs.

*Examination of the Test Meal.*—Amount, 50 cc. On withdrawing the stomach contents and letting it set for about 10 minutes, it divided into three layers, the upper layer consisting of frothy substances, air bubbles and some mucoid material. The middle layer was clear and creamy in color. The lower layer consisted of food particles with a slightly yellowish color. The odor of the stomach contents was sour and unpleasant.

*Chemical Examination.*—Showed that it was acid in reaction; phloroglucin vanilline test positive. The amount of free H. C. L., 40 cc.; the amount of total acidity, 60 cc., thus showing an increase in the amount of free H. C. L. Mett. proteolytic test by albumen tubes equals 4.5 millimetres.

*Microscopic Examination.*—Showed nothing abnormal; some yeast fungi; starch granules; some fat globules; no sarcina; no muscle fibers.

*Urine Examination.*—Urine was pale amber in color; amount in 24 hours was 900 cc.; slight

odor; no shreds; specific gravity, 1021; reaction neutral.

*Chemical Examination.*—No sugar; no albumin; no acetone; no diacetic acid; indican excessive.

*Microscopic Examination.*—Negative; few hyaline casts; no granular casts; no blood casts; no cells.

*Blood Examination.*—Hemoglobin index, 80; red, 4,850,000.

*Examination of Feces.*—Microscopic: Feces were hard cylindrical dark brown masses, and no food particles. Weber's guaiac test positive when no meat had been eaten for 24 hours.

*Chemical Examination.*—Negative; occult blood in traces.

*Microscopic Examination.*—Showed no ova of parasites; some yeast fungi.

#### MEASUREMENTS OF PATIENT.

From sternum to xiphoid.....	9½ inches
" manubrium to umbilicus.....	16 "
" umbilicus to symphysis.....	6¾ "
" xiphoid to left superia spine ..	10½ "
" xiphoid to right superia spine ..	10½ "
Between the spines.....	9½ "
Ankle at xiphoid.....	85 degrees
Circumference at xiphoid.....	23 "

#### TREATMENT.

*Prophylactic.*—If gastralgias are frequent the diet should be mostly of milk for about two weeks. Avoid sudden deviation in temperature of food. If not relieved, then feeding by rectum exclusively. This was fortunately not found to be necessary.

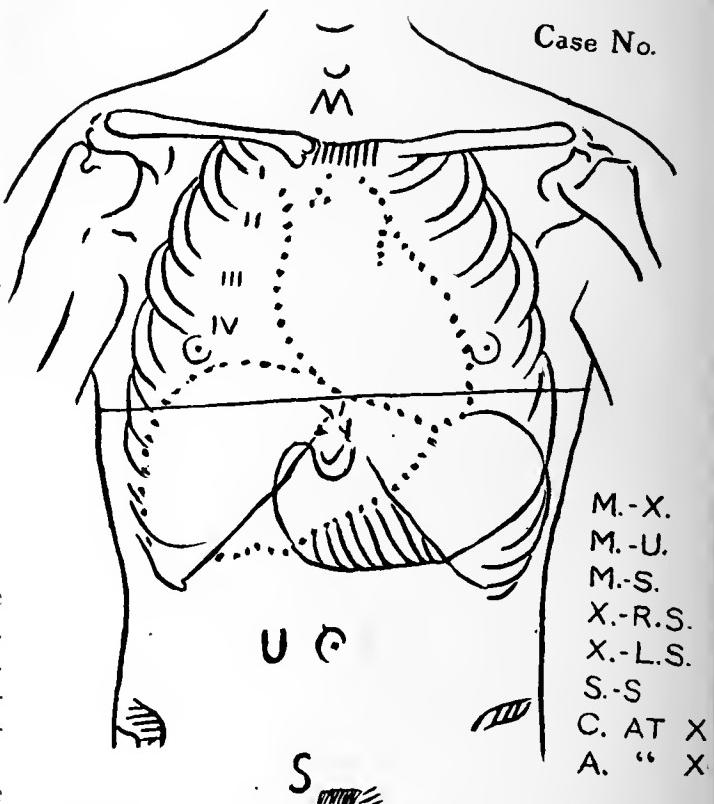
Daily evacuation must be affected by suitable food and the hyperacidity remedied.

*Dict.*—Morning, two cups of coffee or tea, with 100 grains of milk, 20 gms. of sugar, one sweet-bread; 10 o'clock, 200 gms. of bouillon, one egg; noon, 200 gms. of soup, 150 gms. of roast fowl, 100 gms. of carrots or spinach, 200 gms. of light flour food; 4 o'clock, two cups of tea, coffee with 100 gms. of milk, 20 gms. of sugar, one sweet-bread; evening, 100 gms. of cold roast meat, 250 gms. of tapioca; 10 o'clock at night, 250 gms. of milk.

*Medical Treatment.*—Hot application to epigastrium is of value if there is lots of pain. Silver nitrate, 2.5 grams to 120 cc. of peppermint water one tablespoonful three times a day, then the dose can be increased to 0.3 grams AgNO<sub>3</sub> to

120 of water, and finally 0.4 grams AgNO<sub>3</sub> to 120 of water, combined with this, rest and a sparing diet.

Bismuth subnitrate can also be effectively used (10 to 20 gms. stirred into 200 cc. of warm water) after the stomach has been thoroughly cleaned by lavage. This suspension is poured in the stomach and allowed to remain three minutes; the clear water is siphoned out and the bismuth remaining behind and forming a coating to the injured places in the stomach; or, the bismuth salts can be in-



Height.....Weight.....Age.....  
X Angle.....Pr. Weight.....

sufflated into the stomach in a dry form. If there is an ulcer the coating is held longer in the crater of the ulcer than on the uninjured part of the stomach, and can then be photographed by the X-ray, according to the special method first described by Prof. Hemmeter (see introduction). According to the most recent publication on the comparative results of purely medical and dietetic (non-operative treatment) and surgical treatment of gastric ulcer (quoted by our professor), the last results are obtained by internal medical treatment, and not by surgery. Prof. Hemmeter

quoted L. Bamberger—"Die innere ei. die chirurgische Behandlung des chronischen Magengeschwürs u. ikve Enfolge."

Bamberger concludes (p. 164) that surgery is in its proper sphere only for the complications of gastric ulcer, examination, uncontrollable hemorrhage, vomiting, perforation and symptoms of pyloric abstraction. These complications he demonstrates to be the exception. He emphasizes that the treatment of chronic gastric ulcer when uncontrolled is the object of internal medical—not surgical—treatment.

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JULIAN JOHN CHISHOLM, M.D., LL.D.,  
PROFESSOR OF OPERATIVE SUR-  
GERY AND OF EYE AND EAR  
DISEASES.

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BY RANDOLPH WINSLOW, M.D., LL.D.

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Dr. Julian J. Chisholm was born in Charleston, S. C., on April 16, 1830, and graduated from the Medical School of the State of South Carolina in 1850. He subsequently went abroad and continued his medical studies in London and Paris, and upon his return home he became connected with his alma mater as an instructor in surgery and became professor of surgery in the same school in 1858. During the Civil War he held an appointment as surgeon in the Confederate States Army and treated the first wounded in that war—at Fort Sumter. Upon the termination of the war he resumed his chair in the Medical College of South Carolina, but removed to Baltimore in 1868 and took up the specialty of eye and ear diseases, and the same year was made professor of military and operative surgery in the University of Maryland, and the year following the new chair of operative surgery was created for him, with the addition of a clinical professorship of diseases of the eye and ear. In 1873 he retired from the teaching of operative surgery and was made professor of eye and ear diseases, which chair he continued to hold until his retirement in 1895 on account of ill health, when he became emeritus professor of eye and ear diseases. Dr. Chisolm was one of the most distinguished men who have ever held chairs in the University of Maryland. He was of Scotch ancestry and inherited to a large degree the characteristics of this race of people. He was a skilful operator, both as a general surgeon and as a specialist in

eye and ear diseases, and was a teacher of rare ability; indeed, the present writer can say truthfully that he was the most impressive teacher whom he has ever had the privilege of listening to. His manner of speech was sharp, decisive and to the point, and after the lapse of over a third of a century many of his axioms remain firmly imbedded in the memory. He was pre-eminently a teacher. Some of the subject-matter of his discourses may not have been correct, but, correct or incorrect, it remains indelibly upon the memory. He possessed no elegance of speech, but a ruggedness and forcefulness of diction that served to impress his meaning upon the mind with indelible persistence. He was an author of great industry, and the titles of his various writings will run into the hundreds. During the Civil War he wrote a manual of operative surgery for the use of the surgeons of the Confederate Army which passed through several editions, and which he was asked to revise many years subsequent to the war, but declined to do so on account of having ceased the practice of general surgery. He was a firm believer in the use of chloroform as a general anesthetic, and claimed to have administered it over 10,000 times without serious accident. He was dean of the medical department of the University of Maryland from 1869 to 1874. He founded the Baltimore Eye and Ear Institute in 1871, and in 1877 he instituted the Presbyterian Eye, Ear and Throat Hospital on East Baltimore street, beyond the Falls, which has been attended with great success from its inception, and is still one of the most prominent special hospitals in this country. Dr. Chisolm was of medium height, dark complexion, with dark hair and beard, until advancing age silvered it with gray. He was immaculately neat in his dress, and was a most attractive person in speech and manner. He was twice married, the only surviving child of his first wife being his son, Dr. Francis M. Chisolm, associate professor of ophthalmology in the University of Maryland. In 1894 he married his second wife and went on a bridal trip to Europe. Whilst he was on the ship on his return he was stricken with aphasia, from which he never entirely recovered, and was forced to discontinue his lectures in the University. He continued for a short time the practice of his profession, but left Baltimore in 1898 and spent the remaining years of his life in Petersburg, Va., where he died No-

vember 1, 1903. The degree of doctor of laws was conferred on him by an institution in the South, the name of which I cannot recall.

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ADDRESS OF THANKS TO DR. CHARLES  
MAYO AT THE CONCLUSION OF HIS  
COURSE OF LECTURES ON "THE  
SURGERY OF THE THYROID  
GLAND," EXPRESSED BY PROF.  
JOHN C. HEMMETER, REPRESENT-  
ING THE REGENTS OF THE UNIVER-  
SITY OF MARYLAND.

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After the conclusion of Dr. Charles Mayo's lecture, Professor Hemmeter spoke as follows:

"A few minutes ago Professor Winslow informed me that the Regents of the University of Maryland had designated me to express to Dr. Charles Mayo their appreciation of this course of lectures and their thanks for his visit.

"This audience, I can divine, has during the progress of this lecture come to the conclusion that we were not listening to a surgeon in the ordinary sense of the word.

"His firm reliance on the fundamental sciences that constitute the bed-rock of medicine, namely, chemistry, physiology, anatomy; the wonderful facility with which the clearest of expression and description was given to the most intricate problems of immunity and the graceful interweaving of facts from the history of medicine, introduced to bring seemingly discordant events in the narrative of the development of conceptions on thyroidism into unity, stamp this man as a scholar of the rarest penetration, of broad experience and conservative critical judgment. Well has it been said by Lincoln, and later by Mr. Greeley, 'Westward the star of empire takes its way,' and similarly may we say today, impressed by the classic thoroughness and technical brilliancy of the messages communicated to us, 'Westward the star of surgical progress takes its way.'

Then turning to the lecturer, Professor Hemmeter continued:

"Dr. Charles Mayo, your home in Rochester, Minn., has been a 'mecca' for many of our surgeons, and we deem it a high honor to bid you welcome in this ancient hall. Your distinguished brother, sir, is an alumnus 'honoris causa' of this venerable University, and tomorrow the Regents

of the University of Maryland will place your own name on the roll of honor."

Again addressing the audience, Dr. Hemmeter said: "Fellow-practitioners, alumni, colleagues of the various faculties and students, as a simple outward manifestation of our appreciation, let us rise and offer a standing vote of approval of the genius of our esteemed guest."

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THE PART THE UNIVERSITY OF MARY-  
LAND PLAYED IN OPHTHALMOLOG-  
ICAL DEVELOPMENT IN AMERICA.

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Dr. Horatio Gates Jameson was an early Baltimore surgeon, by some acclaimed the greatest surgeon America has produced, whose work included the treatment of diseases of the eye. He was born in York, Pa., in 1788, and died in Baltimore in 1855. He graduated in medicine from the medical department of the University of Maryland in 1813, and immediately located in Baltimore, where he soon attained high rank as a surgeon and physician. He was the founder of the medical department of Washington College (1827), and was its professor of surgery from the time of organization until 1835. He made numerous contributions to surgical literature, among which was the essay, "Observations Upon Traumatic Hemorrhage, Illustrated by Experiments Upon Living Animals," in which he demonstrated anew the use and value of animal ligatures. His teachings on this subject, although sustained by the authority of Dr. Physick, was not appreciated by contemporary surgeons, and it was forgotten until after the method became popular as one of the features of antiseptic surgery.

He appears to have been much interested in diseases of the eye. He undoubtedly included them in his surgical practice and teaching, and wrote some instructive papers pertaining to them (Hubbell, "The Development of Ophthalmology in America"). Dr. Harry Friedenwald cites some of them, which were published in Jameson's own journal, the *Maryland Medical Recorder*. One was on the "Pathological Sympathy Between the Eye and the Larynx;" another, "A Case of Enlargement of the Eye Following the Entrance of Steel Into the Eye;" again, "Two Cases of Ossification of the Lens, with Luxation Through the Pupil," and still again, "Amaurosis Associated

with Inordinate Thirst." He also published another paper giving an account of the successful removal of "An Encysted Tumor of the Orbit."

Dr. Nathan R. Smith was another notable Baltimore surgeon and teacher who was also eminent as an ophthalmic surgeon (Hubbell, "Ophthalmology in America"). He was born in Concord, N. H., in 1797, and died in Baltimore, Md., in 1881. He was the son of the great physician and surgeon, Nathan Smith of New Haven, Conn., and received both his classical and medical education at Yale, in which his father was one of the professors. He graduated in medicine from that institution in 1823. Dr. Smith was successively attached to medical schools in Philadelphia, Lexington, Ky., and Baltimore, the principal part of his professional career having been spent in the last-named city. He had an inventive mind, and added considerable to the instrumental and operative improvements of both surgery and ophthalmology. Dr. Smith devised a knife for dividing strictures of the nasal duct. He operated with this instrument at least as early as 1846. He also used gold lachrymal canulae of his own device, which were an improvement on the old forms. Dr. Smith was the grandfather of the distinguished oculist, Dr. Theobald, a graduate of our institution, and a professor in the Johns Hopkins University.

## ITEMS

The officers of the Maryland Medical College Faculty are: President, A. D. McConachie, class of 1890; vice-president, J. W. Funk, M.D., class of 1888; dean, Harry Gross, M.D., class of 1896; assistant dean, W. S. Smith, M.D., class of 1883.

On the board of directors of the Maryland Medical College are: Harry Gross, M.D., vice-president; J. W. Funk, M.D., treasurer; W. S. Smith, M.D., and C. Urban Smith, M.D., class of 1880.

On the board of directors of Franklin Square Hospital are: C. U. Smith, M.D., president; J. W. Funk, M.D., vice-president; W. S. Smith, M.D., secretary-treasurer; Fred Caruthers, M.D., class of 1892; Harry Gross, M.D.; A. D. McConachie, M.D., and Albert T. Chambers, M.D., class of 1899.

On the faculty of Maryland Medical College

are: William Herbert Pearce, M.D., Emeritus Professor of Diseases of Children and Clinical Medicine; J. W. Funk, M.D., Professor of Diseases of the Eye; Fred Caruthers, M.D., Professor of Genito-urinary Surgery; W. S. Smith, M.D., Professor of Diseases of Women; C. U. Smith, M.D., Professor of Theory and Practice of Medicine and Gastro-enterology; Harry Gross, M.D., Professor of Operative and Clinical Surgery; A. D. McConachie, M.D., Professor of Therapeutics, and Clinical Professor of Diseases of the Eye and Ear; W. S. Love, M.D., class of 1890, Professor of Materia Medica and Clinical Medicine; E. Miller Reid, M.D., class of 1864, Professor of Medical Jurisprudence; Albert T. Chambers, M.D., Professor of Anatomy; Thomas J. O'Donnell, M.D., Associate Professor of Surgery and Chief of Clinic in the Chair of Operative Surgery; Thomas J. Talbott, M.D., class of 1895, Associate Professor of Gynecology; H. D. Lewis, M.D., class of 1900, Associate Professor of Operative Surgery, and J. Gilbert Selby, class of 1899, Demonstrator of Anatomy.

On the visiting staff of the Franklin Square Hospital are: Surgeons, Drs. J. W. Funk, F. Caruthers, W. S. Smith, Harry Gross, A. D. McConachie and Albert T. Chambers; physicians, Drs. C. U. Smith, Pearce Kintzing and W. H. Pearce.

Dr. T. J. O'Donnell is Chief of Clinic to the Chair of Operative Surgery, Maryland Medical College.

Dr. Charles Wattenscheidt is a resident of Orlando, Fla.

Dr. Charles W. Fogel is a member of the United States Health and Marine Hospital Service.

Dr. Robinette B. Hayes, class of 1906, assistant in the clinical laboratory, has resigned to assume charge of St. Luke's Hospital, Fayetteville, N. C. He will later be joined by Dr. T. Marshall West, now assistant resident surgeon University Hospital.

Dr. Charles O'Donovan, class of 1881, of Baltimore, recently addressed the students of St. Joseph's College in the college hall on "General

"Hygiene with Special Reference to Youth." The lecture embraced such topics as the germ theory, athletic training, the use of tobacco and stimulants.

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Dr. Louis Armstrong, class of 1900, is located at Beckenridge, Minn.

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Dr. and Mrs. J. Edward Benson of Marble Hill, Cockeysville, Md., have announced the engagement of their daughter, Miss Edna L. Benson, to Mr. Clarence Martindale Gifford of Rising Sun, Cecil county, Maryland. The marriage will take place in the spring.

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Orders issued by Secretary of the Navy Meyer February 23, 1910, placed Medical Director George E. H. Harmon, class of 1872, of Maryland, on the naval retired list for age March 5.

Dr. Harmon, one the most able naval medical officers, was born in Maryland 62 years ago, and appointed to the service from his native State December 20, 1873. He was promoted through the various grades to the highest rank in his corps December 15, 1904. He stands sixth in his corps at present. He has been in charge of the Medical School Hospital since August, 1908. Of his service, 17 years and six months were spent afloat and 15 years and 10 months on shore.

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Governor Crothers of Maryland has reappointed Dr. J. B. Norris, class of 1866, as Police Examiner for Baltimore, Md.

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Dr. G. Lane Taneyhill attended the sixteenth annual reunion and banquet of the Baltimore Alumni Association of Dickinson College, held at the Hotel Rennert, Baltimore, February 11, 1910. Amongst the speakers was Dr. William Herbert Pearce, class of 1891, who spoke on "The Functions of an Alumnus Association." Drs. G. Lane Taneyhill and William Herbert Pearce were elected members of the executive committee for the ensuing year.

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Amongst the recent visitors to the University Hospital was Dr. William S. Maxwell, class of 1873, of Still Pond, Kent county, Maryland.

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The last meeting of the Baltimore County Medical Society was held recently in the rooms of the Board of Health at Towson Maryland. Papers

were read by the following of our alumni: Drs. A. L. Wilkinson, J. Mason Hundley and Bennett F. Bussey, class of 1885.

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The faculty and adjunct faculty of the Department of Medicine, University of Maryland, tendered the senior medical class of that institution a buffet supper Saturday evening, February 26, 1910. A similar affair was held in 1907, and its success prompted a revival of the custom, which we sincerely hope is to be a permanent feature of the college year. Music was furnished during the evening by a stringed orchestra. Everybody was out for a good time, both doctors and near-doctors, and the affair proved to be a huge success, thanks to the efficient service of Dr. William D. Scott, who had complete charge of the arrangements. More than 150 attended the function, which was held in the main lecture hall of the Law Building.

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The last regular meeting of the University of Maryland Medical Association was held in the amphitheatre of the University Hospital Tuesday, February 15, 1910, at 8.30 P. M. The program was as follows: "Psychasthenia and Neurasthenia," Dr. Bruns; "Epilepsy," Dr. N. M. Owensky; "Peripheral Nerve Lesions, with Exhibition of Cases," Dr Settle; "Spinal-Cord Lesions, with Exhibition of Cases," Dr. Schwartz; "Brain Lesions, with Exhibition of Cases," Dr. Hawkins. Dr. John T. O'Mara, the president, occupied the chair.

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Dr. W. R. Eareckson read a paper entitled "Treatment of Miscarriage from the Standpoint of the General Practitioner" at the meeting of the Section on Gynecology and Obstetrics of the Baltimore City Medical Society, Friday, February 11, 1910.

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Dr. Albert H. Carroll, who has been quite ill with the grip, is out again.

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Miss S. R. Blandford, a graduate of the University Hospital Training-School for Nurses, was elected treasurer of the Maryland State Association of Graduate Nurses at their recent meeting.

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Dr. Joseph Blum, class of 1885, of 1816 Madison avenue, Baltimore, was born in Maysville,

Ky., March 19, 1861. He received the degree of Ph.G. from the Maryland College of Pharmacy in 1883; then matriculated in the medical department of the University of Maryland, whence he was graduated with the degree of M.D. in 1885. He is visiting physician to the Hebrew Hospital.

Dr. and Mrs. Francis Miles Chisolm, formerly of Baltimore, were hosts at a luncheon at the Chevy Chase Club, Washington, recently.

Dr. Howard J. Maldies, class of 1903, has been appointed director of the pathological laboratory of the University Hospital.

Dr. John Henry Bolton was born in Louisville, Ky., September 13, 1840. He received the degree of Ph.G. from the Maryland College of Pharmacy, now the pharmaceutical department of the University of Maryland, and was graduated in 1862 with the degree of M.D. From 1863-1865 he was assistant surgeon to the Seventh Regiment of Maryland Volunteers, U. S. A.

Dr. and Mrs. Louis McLane Tiffany of 831 Park avenue, Baltimore, have left for a six weeks' visit to the South.

Dr. Charles C. Billingslea, class of 1900, and captain in the medical corps of the United States Army, has been ordered to report in person to the commanding general, Department of California, on arrival at San Francisco from the Philippines for assignment to duty at Army General Hospital, San Francisco.

Dr. Benjamin H. Dorsey, class of 1901, Past Assistant Surgeon, United States Navy, has been detached from the Washington and ordered to duty at the Naval Hospital, Puget Sound, Washington.

Dr. J. A. Nydegger, surgeon, United States Public Health and Marine Hospital Service, was granted three days leave of absense, commencing February 17, 1910.

Dr. A. C. Smink of Norwood avenue and Liberty road, West Forest Park, Baltimore county, Maryland, was thrown from his buggy in front of his home by colliding with a Gwynn Oak

car. He was only slightly injured about the body, but the buggy was demolished.

Dr. Randolph Winslow read a paper—"The Diagnosis and Treatment of Tubercular Peritonitis"—before the Section on Clinical Medicine and Surgery, Baltimore City Medical Society, March 4, 1910.

Dr. J. Marshall Price of Frostburg, Md., has been elected a censor for the Georges' Creek Medical Association for the ensuing year.

The Phi Delta Epsilon Fraternity held its annual dance Thursday evening, February 10, 1910, at Lehmann's Hall.

Dr. Jay Ralph Shook, class of 1899, of the United States Army, medical corps, has been promoted from captain to major, his commission to date from January 1, 1910. Dr. Shook was a former interne of the University Hospital, and entered the army during the Spanish-American War. His many friends will no doubt be glad to hear of his promotion.

Dr. C. W. Vogel, Past Assistant Surgeon, United States Public Health and Marine Hospital Service, was detailed to represent the service at the meeting of the American Society of Inspectors of Plumbing and Sanitary Engineers, Trenton, N. J., January 20-22, 1910.

The following of our alumni, members of the City Health Department, attended the recent oyster roast held at the Arundel Boat Club shore: Drs. George W. Hemmeter, R. A. Warner, Vernon F. Kelly, H. J. Hahn, M. G. Smith, W. R. Stokes and H. W. Stoner. Dr. Harry W. Stoner was on the committee on arrangements.

Dr. Zachariah D. Ridout, class of 1869, a prominent physician of St. Margaret's, Anne Arundel county, and his daughter Elise, 11 years old, are being immunized to hydrophobia, owing to wounds on the hands, which were inflicted by a supposedly rabid dog. Whilst undergoing treatment they are stopping at the home of Dr. Wirt A. Duval, 2435 West North avenue, also a graduate of our school.

Dr. Edward M. Wise, class of 1877, of 706

North Howard street, was thrown from his carriage recently by a collision with a Linden avenue car in front of the physician's residence. Dr. Wise received a cut on the head, and the carriage was badly damaged.

Dr. Benjamin R. Ridgely, class of 1847, aged 86, and his wife, whom reside on Delight Farm, on the Pot Spring road, near Warren, Baltimore county, Maryland, had a narrow escape from asphyxiation by coal gas in their home recently.

Dr. Ridgely is one of the best-known men in his section of the State, where he has lived all his life, and until a few years ago was in active practice.

Dr. Elijah Tracy Bishop, class of 1855, practices at Smithsburg, Md. He was born at Smithsburg, Washington county, Md., April 11, 1833, and is a son of the late Dr. Elijah Bishop. He is a B.A. of Franklin-Marshall College (1848).

At a meeting of the adjunct faculty of the University of Maryland, held January 25, 1910, several important matters were brought up for consideration and committees appointed to investigate these and to formulate plans whereby conditions would be improved.

A committee consisting of Drs. Wilson, Bay and Spear was appointed and instructed to formulate plans whereby the methods of teaching in the dispensary would be made more systematic and thorough.

Drs. Hayes, Hirsh, Holland and Spear were appointed a committee to draw up plans for an entirely new and modern curriculum.

Both of these committees are to report back to the adjunct faculty, and if their work meets with approval the same is to be sent to the senior faculty.

It was also decided to give a smoker, to be held on the last Saturday in February, to the senior class.

In order to promote the work and standing of the university and to convince the senior faculty that we are interested and in earnest, it is necessary that members endeavor to attend the meetings of the adjunct faculty and take part in the discussion of the matters of import confronting us.

Although insignificant in comparison to the enormous endowment foundations of many of our sister schools of learning, year after year witness-

nesses a slow increase in our permanent endowment. Today the secretary-treasurer of the board of trustees of the permanent endowment fund reports \$20,340.75 in hand. This is indeed a measly amount, and far too little for the needs of the institution, but when considered how raised is a monument to the loyalty, self-denial and perseverance of a single alumnus, Dr. Eugene F. Cordell. Year after year Dr. Cordell has been pegging away; no amount has been too little for him to receive thankfully, so that now, after about 20 years of persistent endeavor, he has been able to place to the credit of the institution more than \$20,000. During this time he has met with many discouragements, but he has never turned aside from his cherished project. When the accretions were at a standstill, he still had faith in its ultimate success, and now, through his untiring efforts, the board, through its treasurer, for the first time reports that the \$20,000 mark has been passed. The good work has been started, additions are received more frequently than in the earlier period of the fund, and if the old saying, "To him that hath shall be given," holds true, the increase in the future will be more rapid. During the period of inception and launching of the fund to the present day one man alone, through his untiring endeavors, has made it possible. Very few have lent him a helping hand; in fact, we may truthfully say none. So when the time comes for him to relinquish his endeavors, if the sum will not have reached his ultimate expectations, namely, \$100,000, those interested in the future welfare of the institution may justly say, "Well done, thou good and faithful servant." Yet we do not think we should wait until a man has died before we give recognition to his worth. Therefore we take this opportunity to give publicity to our appreciation of the debt of gratitude the University of Maryland owes Dr. Eugene F. Cordell for his endeavors to create a permanent endowment fund for the institution. The work is purely one of love, and future generations will place a just estimate upon his services, even if the present one does not.

Dr. Ashby C. Byers of Lacy's Springs, Va., has made several visits recently to the University Hospital with patients. Dr. Byers graduated in the class of 1901, and since graduation has built up a most successful practice in Rockingham county, Virginia. He is married and has several children.

In addition to his practice, he is largely interested in farming, and has been most successful in raising a high grade of horses.

Dr. George S. M. Kieffer gave a public lecture recently at Sexton Methodist Episcopal Church, Morrell Park, the subject being "How the Public Can Assist the Medical Profession to Fight Disease."

It may be of interest to members of the class of 1874 to hear that Dr. Martin B. Billingslea, a member of that class, ceased his labors of this earth during the early years of the twentieth century.

Dr. James Howell Billingslea, class of 1864, resides at Westminster, Carroll county, Md.

### MARRIAGES

Dr. Josiah Slicer Bowen, Jr., class of 1903, of Mt. Washington, Baltimore county, Maryland, was married Monday, February 28, to Mrs. Elizabeth A. Buffington of Baltimore, Md. The ceremony was performed by Rev. Dr. Wilbur Watkins, Jr., the pastor of St. John's Protestant Episcopal Church. It was witnessed only by the immediate families of the couple. After a wedding trip spent in the North, Dr. and Mrs. Bowen will return to their home on South avenue, Mt. Washington. Dr. Bowen has been located at Mt. Washington ever since graduation, and by diligence and constant attention to his profession succeeded in building up quite a large and lucrative practice, and is one of the best known of the younger practitioners of Baltimore county. He is a native of Mt. Washington, where he was born April 28, 1882, and is a son of the late Dr. Josiah Slicer Bowen, Sr., also a graduate of our institution (class of 1862), likewise a practitioner of the town of Mt. Washington for over 30 years. Dr. Bowen (the younger) was educated in the public schools of Baltimore city and county, and Marston's University School, Baltimore. He received his medical education in the University of Maryland, whence he graduated with the class of 1903, since which event he has taken post-graduate work in the clinics at Liverpool University, Liverpool, England. He is a member of the American Medical Association, Medical and Chirurgical Faculty of Maryland, Baltimore County Medical

Association, etc. Dr. Bowen has always taken a keen interest in the affairs of the University of Maryland, and is a constant attendant at its banquets. He is a loyal alumnus, and the BULLETIN takes great pleasure in wishing him much happiness in his new venture.

Dr. John I. Pennington, a well-known physician of Baltimore, and one of the most loyal of our alumni, was married Thursday, February 17, 1910, to Miss Blanche Bantz. The marriage was celebrated in Annapolis, the ceremony being performed by Rev. R. F. Humphries of St. Peter's Protestant Episcopal Church. After the ceremony Dr. and Mrs. Pennington left immediately for Jacksonville, Fla. The bride is a sister of Mr. Gideon C. Bantz, assistant treasurer of the United States. This is Dr. Pennington's second matrimonial venture, his first wife being Miss Virginia Marston, whom he married March 21, 1876.

Dr. Pennington has practiced in Baltimore for more than 35 years. He is a native of Kent county, Maryland, where he was born December 10, 1842. He is a son of the late James H. and Martha J. Pryor Pennington. Dr. Pennington acquired his earlier education in public schools, and his professional education in the medical department of the University of Maryland, whence he was graduated with the doctor's degree with the class of 1869. Dr. Pennington has always taken an active interest in the affairs of the university, and at present is treasurer of the Medical Alumni Association.

### DEATHS

Dr. William Whitridge, a member of the old Whitridge family of Maryland, and at one time one of the most prominent physicians of Baltimore, died suddenly Sunday, February 6, 1910, at his home, 829 North Charles street, Baltimore, Md., from heart disease. Dr. Whitridge was in his seventy-first year. He gave up the practice of his profession some 20 years ago. He had been in bad health for some time, but had been able to get about, and his death came like a lightning stroke out of a clear sky. Dr. Whitridge was a son of the late Dr. John Whitridge, and was never married. Dr. John Whitridge Williams of this city is a nephew. Dr. Whitridge was very prominent in social circles. He was also well known for the interest he took in the Society for

the Prevention of Cruelty to Animals, and at one time was president of the society.

Dr. William Whitridge was born in the city of Baltimore in the year 1840. He was the son of John Whitridge, a physician. He received the degree of Master of Arts from the University of Maryland School of Letters (the old schools of Beau Arts) in 1859, and that of Doctor of Medicine from the medical Department of the University of Maryland in 1862. Since his retirement from active practice he had been engaged in financial and manufacturing enterprises.

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Dr. Philip W. Boyd, Sr., of Winchester, Va., 63 years of age, died February 13, 1910, following a long illness of Bright's disease. He was the son of the late Rev. Dr. Andrew Hunter Holmes Boyd, a noted Presbyterian preacher of Winchester. Dr. Boyd served in Rockbridge Battery of artillery during the Civil War. He leaves a widow and five sons—Dr. P. W. Boyd, Jr., and Fred S. Boyd of Winchester; Dr. John O. and Hunter Boyd of Roanoke, and Henry Boyd of Chicago, and three daughters—Mrs. Fred L. Glaize, Misses Sallie and Ellen Boyd of Winchester, and one brother, Judge Andrew Hunter Boyd of Cumberland, Md., Chief Justice of the Maryland Court of Appeals.

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We are extremely sorry to announce that his Maker has called Dr. Frank Weber, a member of the class of 1909, of Oakland, Md., from his earthly labors. Dr. Weber was suffering with general tuberculosis, the dissemination occurring through an infected kidney, and had just entered on the practice of his profession when taken ill. He was 24 years old, and a son of the late Henry Weber. Dr. Weber was an excellent student, and we are extremely sorry that his light was snuffed so suddenly, as he had the qualities which go to make success in this world—patience, perseverance and honesty.

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Dr. H. M. McNatt, class of 1881, of Maxton, N. C., died recently in his home at Maxton. Owing to poor and failing health, he was compelled to retire from active practice several years ago.

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Dr. W. Lee, class of 1865, died recently at his home in North Carolina.

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Dr. Julius O. Dorsey, class of 1863, died at

his home, near Parker's Landing, Md., January 4, from pneumonia, aged 67.

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Dr. Charles Thomson, class of 1867, for many years a practitioner of Middleburg, Md., but later of Baltimore, died in Frederick January 15, 1910, from pneumonia, aged 67.

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Dr. William H. Clendenen Teal, class of 1897, formerly a medical examiner in the Baltimore public schools, died at his home in Baltimore January 28, aged 35.

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Dr. Joseph Shotwell Smith, class of 1891, of Wheeling, W. Va., a member of the West Virginia State Medical Association, and for eight years a member of the staff of Glendale Hospital, died in Haskins' Hospital, Wheeling, January 19, 1910, from cirrhosis of the liver, aged 42.

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Dr. Edward W. Day, class of 1853, of Vacaville, Cal., died in St. Joseph's Hospital, San Francisco, February 25, 1910.

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Mrs. Jane Parry Winslow, widow of Dr. Caleb Winslow, mother of Drs. Randolph Winslow and John Randolph Winslow, and grandmother of Drs. Nathan and Fitz Randolph Winslow, all connected with the University of Maryland in some capacity or other, died Monday, February 14, 1910, in the eighty-first year of her age at her home, 514 Woodlawn road, Roland Park, Md.

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Dr. Floyd Johnson Smith, class of 1895, of Barracksville, Va., died at the Cook Hospital, Fairmont, W. Va., February 6, 1910, from pneumonia complicating typhoid fever, aged 38.

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Dr. Leswie Colton Keerans, class of 1902, a member of the American Medical Association, surgeon-in-chief to Mercy General Hospital, Charlotte, N. C.; professor of chemistry and physiology in St. Mary's College, Belmont, N. C., died in Belmont February 7, 1910, from pneumonia, aged 32. Dr. Keerans was a well-known character around the medical school during his student days, and generally beloved by the student body. He took a great interest in athletics, and was in every movement looking toward the betterment of the University's athletic position. We of that day certainly regret and deplore his early demise.

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No. 2

## GOITRE.

BY RANDOLPH WINSLOW, M.D., LL.D.

(Continued from Page 4, Vol. VI, No. 1.)

### CASE 5.—Colloid Goitre (Cured).

Mrs. M. A. F. was admitted to University Hospital on March 4, 1903, and discharged on March 16. She is a white widow, 45 years of age. About 12 years ago a dressmaker, whilst fitting a dress on the patient, discovered an enlargement in the neck. This remained rather stationary until five years ago, when it began to increase in size, and it is now about the size of a large orange.

*Operation.*—Under cocaine infiltration, and without a general anesthetic, the right lobe of the thyroid and a large portion of the left was excised. A crescentic incision, with its convexity downward, was made; the skin and platysma retracted upward, and the deep cervical fascia divided, exposing the gland. The veins and right superior and inferior arteries and the left superior thyroid vessels were ligated. The thyroid gland was now dislocated, and the whole right lobe, the isthmus and a portion of the left lobe were removed. Drainage was employed for a few days. She made an excellent recovery and was able to return to her home in 12 days. She suffered some during the operation, but bore it bravely. She was referred to me by Dr. Summers of North Carolina.

### CASE 6.—Colloid Goitre (Cured).

W. S.; white; male; aged about 18 years; admitted March 11, 1905; discharged March 23, 1905.

### CASE 7.—Adenomatous and Colloid Goitre (Cured).

Mrs. H. A. T.; white; aged 50 years; admitted May 1, 1906; discharged May 10, 1906.

*History.*—Goitre appears to be hereditary in



CASE VI.

the family, the patient's mother, sister and daughter all having been affected with the disease. The present trouble has been in existence as long as she can remember, but remained almost stationary until two years ago, when it gradually enlarged, but did not cause distress until three weeks before admission, when she thinks she caught cold. Since that time her breathing has been more or less interfered with. She has been rather nervous, but not to a great extent. Her habits have been good and her general health excellent. Referred to me by Dr. John R. Winslow, and Dr. Ridout of Annapolis, Md. Admitted to hospital May 1, 1906. A tumor the size of an orange was seen on the front of the neck, but mostly on the left side. The lump was firm, painless and movable under the skin. Pulse rate between 80 and 90 per minute. There was some interference with respiration. There was no exophthalmos; urine normal. May 3, 1906, patient having been prepared in the usual manner, morphia sulph., gr.  $\frac{1}{6}$ ;

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scopolamin, gr. 1 1-100, was given one-half hour before the operation. The skin was then anesthetized by the hypodermic injection of Schleich's solution of cocaine. The incision was crescentic in shape, extending from the anterior border of one sterno-mastoid muscle to the other. The skin was dissected upward, the capsule of the tumor exposed and incised, and the mass enucleated. The capsule was very vascular and was the only structure which caused difficulty from hemorrhage. A drainage tube was placed in the cavity from which the tumor had been removed and the skin was sutured with catgut. She complained somewhat of pain during the operation, but bore it well. The drainage tube was removed in 48 hours, and she was discharged well at the end of a week. Highest temperature was 102°, pulse 120, respiration about 33.

*Microscopical Report.*—Section of tumor consists almost wholly of glandular tissue, with some fibrous tissue stroma; many of the glands contained colloid material.

*Diagnosis.*—Adenoma, undergoing colloid degeneration.

CASE 8.—*Goitre, Probably Graves' Disease (Died).*

R. C.; 27 years of age; married; white; female; referred to me by Dr. John R. Winslow, and Dr. Wolff of Cambridge, Md. She has had heart symptoms for some time, and also difficult respiration. On admission, temperature 99½°, pulse 120, respiration 24. Urine normal, except for a considerable quantity of pus; specific gravity 1026. An enlargement of the thyroid to a moderate degree was present, but no exophthalmos. Patient in fair condition, but with rapid and irritable pulse.

May 13, 1904. *Operation.*—Removal of left lobe of thyroid, using gauze to separate fascia; possibly too much manipulation of the gland; no hemorrhage; patient shocked some. 9 P. M., temperature 103½°, pulse 148, respiration 24; very restless and delirious, and tossing around; morphia and atropia, gr. ¼ and 1-150; digitalin, gr. 1-60, every three hours; infused with salt solution. Wounds dressed on 14th, sponged, when temperature was 102½°. Infused repeatedly; temperature reduced somewhat, but the pulse increased in frequency. Ice cap to head. A tube was passed through the nose and nourishment given. She continued wildly delirious and

restless, and died on May 16. The cause of death was evidently acute thyroid intoxication.

CASE 9.—*Hypertrophied Thyroid Isthmus (Cured).*

Mrs. G. W. M.; admitted May 7, 1905; discharged May 16, 1905.

CASE 10.—*Colloid Goitre (Cured).*

Mrs. C. P.; admitted September 23, 1906; discharged October 3, 1906.

*History.*—She first noticed the goitre coming about 18 years ago, but for the past three years it has been giving her trouble, causing shortness of breath, a quickening of the heart, and pain and fullness of the eyes. These symptoms are not severe while she sits still, but there is some increase in the heart beat when she exerts herself. She does not rest well when lying down on account of shortness of breath. The patient is a well-developed white woman, 39 years of age, eyes rather prominent, with an enlargement of thyroid gland, more on the left than on the right side; firm, slightly movable and not painful to the touch. The patient was admitted on September 23 and operated on September 24. The left lobe of the thyroid and part of the right lobe were removed under local anesthesia. A drainage tube was used for 48 hours. The patient got along nicely after the operation, and on October 3 was discharged, temperature, pulse and respiration being normal and her general condition improved. The highest temperature was 101°; highest pulse 108.

CASE 11.—*Colloid Goitre (Cured).*

Miss I. T.; admitted October 16, 1906; discharged October 28, 1906.

CASE 12.—*Colloid Goitre, with Exophthalmos (Cured).*

Mrs. B. H.; admitted November 9, 1906; discharged November 21, 1906.

*History.*—Housewife; aged 28; white; came to hospital for relief of trouble about the throat, which has existed for some months. It did not trouble her until about three months ago, when she began to experience symptoms of pressure. She had a choking feeling, worse at times, and general depressed condition. Thinks she has become more nervous. The pulse rate is slightly increased. Examination shows woman of healthy

appearance, but a noticeable enlargement about throat, a little more exaggerated on right than left side. It extends, however, across to the left and from immediately below mandible to within one and a half inches of the supraclavicular notch and clavicles. To the palpating hand the mass seems cystic; is not painful. It involves the entire thyroid gland. The heart and lungs are negative; some exophthalmos. The patient came to the hospital on November 9, 1906; operation on November 12, 1906. After due preparation the patient was brought to operating-room under the influence of scopolamine and morphia. The skin above growth was infiltrated with Schleich's solution, a horseshoe incision (convexity downward) was made about three and a half inches long, the gland exposed and released by careful dissection, vessels clamped and ligated, and all but a small piece of the thyroid gland removed. Cavity dried after drenching with hot normal salt solution, muscles replaced and sewed, fascia drawn over rubber tube extending down to bottom of cavity, and then skin approximated and sewed by use of silkworm gut sutures. Dressings applied and patient removed to ward. Complained of little pain. Pulse and respiration, as well as voice, little affected by the operation.

*Microscopic Examination.*—Section shows most of the alveoli to be filled with colloid material, many of them being very much distended; a few not containing colloid are collapsed from surrounding pressure. No evidence of malignancy. Diagnosis: Colloid goitre.

July 16, 1909. This patient is entirely well; the incision scarcely visible, but some enlargement of left lobe of thyroid gland has taken place.

#### CASE 13.—*Colloid Goitre (Cured).*

W. G.; admitted November 17, 1906; discharged December 23, 1906; white; age 17 years; schoolboy, with a swelling in his neck. The swelling came on suddenly.

November 22, 1906. *Operation.*—Thyroidectomy; anesthetic, local infiltration with Schleich's solution.

December 23, 1906. The patient's neck has entirely healed.

#### CASE 14.—*Exophthalmic Goitre (Recovered).*

Mrs. D. G.; admitted January 15, 1907; discharged February 27, 1907.

*History.*—March 2, 1906, the patient was oper-

ated on at the Johns Hopkins Hospital. Local anesthesia was used—morphia and cocaine. The right lobe and the isthmus were excised, with probably the parathyroids of that side. This operation was followed by acute thyroidism and at least a partial paralysis of the right vocal cord. Serum was made from her own gland by Bebe's and Rogers' method. The patient left the hospital July 18 improved and with instructions to come back occasionally to see how the serum was acting. October 1 was her last visit, and her improvement was very marked. There was a rapid recurrence of both the goitre and the symptoms, and the patient entered the University Hospital for operation on January 15, 1907. She is a fairly well-developed girl, 21 years old, who had been married two years. Her voice is husky, hand very tremulous, and her face and arm twitch. Her eyes are very prominent and move considerably. Her heart is very rapid, but no valvular lesions can be made out. She has a hoarse cough, which gives her considerable trouble.

January 24, 1907. *Operation.*—Previous to being taken to the operating-room the patient was given two hypodermic injections of the scopolamine preparation. One-quarter per cent. cocaine solution was injected under the skin in a line which was to mark the place of incision. The integument and platysma were now incised, the line of cleavage extending from about 4 cm. to the right of the median line across to the left side, where it was carried upward and outward about 8 cm. The conelave flap was then turned upward, exposing the site of the new growth. The larger vessels were tied with catgut from time to time. The tissue to be removed was firmly clamped with strong compression clamps and cut away. The cut surface of the remaining gland was firmly ligated with silk. The wound was irrigated with normal salt solution, a rubber tube inserted for drainage, and the skin brought together with interrupted and continuous catgut sutures. The patient was very nervous during the entire operation, the scopolamine apparently not acting as satisfactorily as usual. The pulse was not seriously affected during the operation. The portion of the left lobe removed was about the size of a hen's egg.

January 30, 1907. After the operation, which was performed under scopolamine, morphia and cocaine with much difficulty, as the patient seemed to suffer very much, her condition has been good,

save for a rather high temperature and pulse rate. The highest temperature was  $102\frac{3}{5}^{\circ}$  and the highest pulse rate 155. Both gradually fell. The patient's eye symptoms are much lessened, and she is much more comfortable. The wound still drains considerably, but the tube was taken out today.

February 1, 1907. Since last dressed the patient has rapidly improved. There is no twitching of muscles, except the eyes, which are not so prominent (there is no defective vision). There is slight drainage, but her temperature is normal and the pulse rate is almost normal. Her general condition is much improved, and she is gaining flesh and strength.

February 19, 1907. The patient was discharged today, much improved.

CASE 15.—*Large, Hard Goitre, Fibro-adenoma (Recovered).*

Mrs. B. M.; admitted May 17, 1907; discharged June 13, 1907. Referred to me by Dr. Gichner.

*History.*—The patient is a white woman, 52 years of age, who entered the hospital complaining of a growth in the neck of 12 years' duration. It started as a small lump on the right side of the trachea and grew gradually, giving her some discomfort in breathing and talking. The lump is an enlargement of the thyroid gland, about the size of an orange, densely hard and only slightly movable, and not painful. The large vessels are pushed back behind the sterno-mastoid muscles and the trachea is pushed far to the left of the median line. There is no protrusion of the eyeballs or tremor or nervous symptoms. The pulse rate is slow. Her general condition is good. She has eruptions over her entire body—macular, red, and fading on pressure.

*Operation.*—May 21, 1907. Previous to being brought to the operating-room the patient was given morphia and scopolamine in divided doses,  $\frac{1}{4}$  gr. of the former and 1-150 gr. of the latter. After placing the patient on the operating table the field of operation was scrubbed and rendered aseptic, and the line of incision was infiltrated with Schleich's solution. The patient was placed in a semi-sitting posture. A transverse incision was made across the growth about three inches long. The right lobe of the gland was removed after clamping and ligating the superior and inferior

thyroid arteries and veins and dividing them. The growth was shelled out of its capsule and divided at the isthmus, leaving the left lobe. All bleeding points were ligated with silk, and any oozing was stopped by whipping over the bleeding surface with a continuous silk suture and bathing the wound with a hot salt solution. A drain of small rubber tubing was placed into the lower part of the wound and the incision closed.

The patient was asphyxiated two or three times during the operation from the pressure of the growth on the trachea preventing the entrance of air. But after the growth was removed she breathed freely and soon regained a pink color. She was removed to her room in a good condition, and placed in bed in an almost sitting posture. The day following the operation the drainage tube was removed, and she was allowed to sit up in bed. She has no trouble with respiration, but cannot talk above a whisper. There is no elevation of temperature, but a congestion of the mucous membrane, which was relieved by inhaling steam (benzoin and opium). The patient is rather nervous, but her general condition is good.

One week following the operation: The patient is still rapidly improving. The suture is removed, the wound having healed by first intention. There is considerable discharge from the drain incision, and when irrigated some sloughs are washed out. The patient is up in a chair, still has a defect in voice, but no interference with breathing. She sleeps well, and has no cough or other trouble experienced before the operation. Her neck is down to its normal size, and practically no scar can be noticed.

June 13, 1907. The patient was discharged in good condition, with no embarrassment of respiration. A microscopical examination showed no signs of malignancy.

*Diagnosis.*—Fibro-adenoma of thyroid.

This was a most interesting case. It was by far the most difficult case to operate on that I have ever undertaken. She almost died on the table from asphyxiation, and was only saved by rapidly tearing the growth away from the trachea and thereby releasing the pressure. After she returned to her home she developed difficulty in respiration, and a tracheotomy was done to permit air to enter her windpipe. Her condition failing to improve, she returned to Baltimore and entered the Hebrew Hospital, where Dr. Lee Cohen found a complete

stenosis of her larynx, as well as an outgrowth of the trachea near the bifurcation. With much difficulty he removed these neoplastic structures, which were found to consist of thyroid tissue. The remnants of the right lobe also became developed into a tumor as dense and hard as the original growth. About this time new growths occurred on the head and in other parts of the body, which were reported by the pathologist to be adenomata. A decided paresis also set in, giving the impression that metastases had taken place in the spinal cord. Clinically, the condition was malignant, microscopically benign.

CASE 16.—*Cyst of the Thyroid Gland (Cured).*

L. D.; admitted May 29, 1907; discharged June 22, 1907.

*History.*—The patient is a seamstress, white, and 38 years of age, who entered the hospital on the 29th of May, complaining of nervousness and indigestion. The patient, who is very neurotic, was referred from the medical side, with a rapidly growing lump in the neck, not painful or giving any signs of inflammation, and apparently attached to the thyroid gland. The growth is of about one month's duration, rather soft and elastic on palpation, and about the size of a walnut.

June 14, 1907. *Operation.*—The patient was prepared for operation with ordinary aseptic precautions. She took the ether well and did not struggle. The incision was the usual transverse cut across the neck. A cystic tumor was found in the thyroid gland, which peeled out beautifully. The patient was discharged June 22, 1907, cured of the lump in her neck, but still very nervous.

CASE 17.—*Parenchymatous Goitre (Cured).*

J. V.; admitted July 7, 1907; discharged July 29, 1907.

*History.*—The patient is a rather well-developed colored man, aged 20 years, who has an enlargement of the neck below the hyoid bone. It is not symmetrical, being larger on the right side. This moves when the patient swallows, and feels somewhat cystic. It was diagnosed as an enlarged thyroid gland.

July 15, 1907. *Operation.*—Scopolamine and morphia were used as an anesthetic, with cocaine locally. After the usual aseptic preparation a transverse incision, about three inches long, was made across the swelling, the skin and platysma and deep fascia divided, and the bleeding vessels

clamped; the sterno-mastoid muscle was drawn aside, and the sterno-hyoid and the sterno-thyroid muscles divided. The capsule of the large goitre was divided and stripped off, and the vessels clamped. The finger was passed around the gland, detaching it. The tumor was then drawn forward and its vessels ligated. The isthmus was ligated and then cut, the posterior border being still attached to the trachea, and the tumor was removed, leaving sufficient of the gland to carry on its function. During the operation the patient was very troublesome and was restrained with difficulty.

The drainage tube was removed on the second day, and the incision healed *per primam*. The highest temperature was 101° and the greatest pulse rate 126, each rapidly falling to normal.

CASE 18.—*Simple Unilateral Goitre, Right Side (Cured).*

Mrs. E. R.; entered August 13, 1907; discharged August 26, 1907.

The patient entered the hospital August 13, 1907; a white German woman, 60 years old. August 18, 1907, a large, right unilateral, enlarged thyroid growth was removed without general anesthesia. Scopolamine and morphia hypodermically and cocaine locally were used. The patient was discharged August 26, 1907, cured. The highest point reached by the temperature was 101°; the highest pulse rate was 105. Both of these quickly fell to normal, however. This woman had had this goitre for several years, and it had become so large that she could not bend her neck; it also caused some difficulty in respiration. She was able to sit up out of bed the day after the operation, and had no subsequent trouble. A physician had treated her for many months by giving medicine to cause the tumor to be absorbed—needless to say without any beneficial result.

CASE 19.—*Parenchymatous or Colloid Goitre (Cured).*

Mrs. W. R. V.; white; aged 34 years; admitted September 20, 1907; discharged September 28, 1907.

*History.*—For the past three years she has noticed an enlargement on the right side of her neck just below the thyroid cartilage. This enlargement began to increase in size about three months ago, and for the past month has been growing very rapidly. The patient has no pro-

trusion of the eyes, but she has been nervous and irritable for the past six weeks. She has had some pain, extending up around the ear on the right side, and has also had at times a sense of pressure on the trachea and a husky voice.

*Operation.*—September 21, 1907. Morphia and scopolamine anesthesia, with cocaine injected into the skin. An incision three inches long was made extending across the thyroid gland in a horizontal direction, passing through the skin, subcutaneous tissue and platysma myoides. The other muscles were pulled aside, and all of the right and part of the left lobe of the thyroid gland removed. The vessels were ligated with silk; the platysma myoides sutured with a continuous suture. An incision one-half inch in length was made one inch below the other incision and a small rubber tube inserted. The skin was closed with subcutaneous silver-wire sutures. The tube was removed on the second day. There was quite a reaction following operation, which subsided on the third day. She was discharged on the eighth day, and made an excellent recovery, with an almost invisible scar.

(*To be continued.*)

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## THE HISTORY OF TUBERCULOSIS.

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By LOUIS RUBIN, 1910.

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Tuberculosis is beyond question the most important disease with which the human race has ever been obliged to contend. Its antiquity dates from the earliest records accessible to man. In the oldest Egyptian tablets are found references showing that the physicians of those days had some knowledge of it. Moses, in his writings, gave out hygienic rules for the prevention of consumption. The works of Hippocrates contain a description of the disease so remarkable for its accuracy as to equal a work of modern excellence, although it is the earliest known description we have. In it he speaks of tuberculosis under the name phthisis, phthoe and empyema, and, among other things, describes "the winged scapulae."

In the works of Isocrates is to be found the earliest notice of the opinion that phthisis is infectious. Aristotle states this malady "makes the breath corrupt and offensive, and that those who approach the diseased person breathe air vitiated by him." Plautus, the poet, mentions resin and honey as the Roman remedies for

hemoptysis, and Discoidides, the physician of Cleopatra, and the greatest writer on *materia medica* in ancient times, recommends sulphur, a substance which has been more or less employed in various forms until within the last century for this condition.

With the second century of the Christian era came the great Greek physician, Aretaeus, who wrote an excellent description of the disease, and carefully distinguished it from empyema. He considers ulceration of the lungs as genuine consumption, calls it phthoe and gives a good description of the symptoms. Most of the chapter on treatment is lost, but in what remains he strongly advises milk diet and sea voyages.

Celsus, the philosopher, and Pliny, the elder, enumerated various substances for treatment. It is very interesting to note that Pliny sent his phthisical patients to the pine forests.

Galen, the greatest physician since Hippocrates, was the first to make note in his writings of the expectoration of cretaceous concretions. He sent his phthisical patients to the high dry climates of Southern Africa. The Arabian writers of this period held practically the same views of the nature and treatment of tuberculosis as the Greeks.

The Renaissance terminated a period of about 1500 years of inactivity, during which very little progress was made in all kinds of learning, including medicine. With this awakening came Sylvius, after whom the Sylvian fissure is named, and who taught such great men as Vesalius and Ambrose Paré. It was Sylvius who first taught and described the existence of tubercles in the lymph glands and lungs. Until this time the views of Galen were practically undisputed. Upon beginning anatomic investigation and with the discovery of cavity formation and pus collections, numerous conjectures were offered as to the pathogenesis of the disease. Benjamin Rush of Philadelphia was one of the earliest American writers on the subject, and became famous through his publishing "Some Thoughts on Tuberculosis." From that time on numerous medical giants have taken part in the struggle which even up to the present day is far from won.

Mangetus was probably the first to recognize true miliary tuberculosis. Bayle, in 1810, then distinguished phthisis granulosa as a separate form of the disease. He demonstrated the extensive distribution of peculiar nodules in various organs and their relation to pulmonary tuberculosis.

His description, however, is very imperfect, and does not correspond to miliary tuberculosis, although the history of some of his cases shows that they were undoubtedly of this character. The same criticism may be applied to the observations of Laennec and Louis, who described miliary tuberculosis under the head of acute phthisis. With the appearance of Bayle's work was ushered in a period of remarkable activity throughout the scientific world in wrestling with the much-disussed question of the cause and nature of tuberculosis. Few questions have ever taxed clinical observers and pathologists to such a degree as this. The pathological changes were regarded as specific, and were looked to for the unravelling of the mysteries in which tuberculosis was shrouded.

In 1819 Laennec accurately described the tubercle microscopically. He considered caseated material to be characteristic, and called everything tuberculosis where it was found. He also distinguished the isolated tubercle from diffuse, tubercular, cheesy infiltration. Laennec thus recognized the identity of many processes whose similarity was afterwards often disputed, and has only recently been established, such as the affinity between scrofulous enlargements of glands and tuberculosis, although the specific micro-organism was then unknown. Laennec contributed much to the knowledge of the disease by establishing a more definite relationship between tubercles and consumption. Rokitansky also believed that scrofulous glands and tuberculosis were intimately associated with each other, but insisted upon the significance of a certain adaptability or susceptibility to consumption as displayed by a certain type or "phthisical habitus."

Virchow made a sharp distinction between tuberculosis and new growths and inflammatory processes which had become cheesy. He was, in fact, the first to apply the term caseation. The anatomical criterion of tuberculosis was, in his opinion, the presence of the miliary tubercle, a nodule, the size of a millet seed at the largest, and made up the cells like lymph corpuscles.

Until Virchow cleared matters up somewhat by demonstrating and explaining the pathologic and histologic structure of the tubercle, it seems that pulmonary and miliary tuberculosis were hopelessly confused, inasmuch as the relationship between them was not very clear. Probably the first writer to lay sufficient stress upon the special character of miliary tuberculosis was Waller, who,

in 1845, divided it into five different varieties, while Laudet was content with only three—a typhoid, a catarrhal and a latent form. Microscopic research had been previously undertaken by Lebert, who described the so-called "tubercle corpuscle" as a non-nucleated cell in the midst of tubercle formation. Wagner, Schöppel, Langhans and others now early took up the study of the microscopic structure of the miliary tubercle. They were, however, unable to agree as to its origin and significance.

The first efforts toward inoculation experiments were made in the early part of the nineteenth century, and were not attended with clearly definable results. Consequently there was much speculation concerning the possible infectiousness or transmissibility of tuberculosis. In 1843 Klencke furnished the first experimental evidence of the inoculation transmission of the disease. He inoculated rabbits with tuberculous material, and at autopsy 26 weeks later found disseminated tubercle deposit in the liver and lungs. This experiment pointed unmistakably to the only way which would eventually lead to a correct knowledge of tuberculosis.

In 1857 Buhl promulgated the doctrine of the origin of miliary tuberculosis as a result of the distribution, through the medium of the circulation, of an agent derived from an era of infection within the body, and that it bears the same relation to the primary lesion as pyemia does to a focus of suppuration. Tuberculosis of the thoracic duct was first accurately described and studied by Sir Astley Cooper.

In 1865 Villemin conducted a series of inoculation experiments of the greatest value. In addition to introducing into animals an infective material obtained from tuberculous tissues and the sputum of consumptives, he injected into a second class non-tuberculous, and into a third the caseous matter from tuberculous cows. A tuberculous deposit was found after their introduction of purely infective matter from any source, confirming the theory of the specific infectious nature of the disease. An apparent identity of human and bovine tuberculosis was also suggested by the demonstration of tuberculous changes in all instances, irrespective of the derivation of the infective agent. Although doubted and vigorously opposed at first by many, the fact that tuberculosis can be transmitted, and consequently the fact of

its infectious nature, must now be regarded as proved beyond a doubt.

Cohnheim and Salomonsen contributed prominently to the acceptance of Villemin's teachings by their most instructive method of inoculation into the anterior chamber of the eye of a rabbit. In this manner opportunity was afforded for visual inspection, as after an incubation period of two to three weeks we see here very plainly an eruption of the first nodules of tubercle in the iris, and later the tuberculosis spreads to other organs.

Experiments by Gerlach, Bellinger, Aufrecht, Chaveau, Leisering, Harms, Gunthern and others showed that the disease may be communicated by incorporating tuberculous matter with food, i. e., infection may take place by way of the intestinal tract. Experimental inoculation thus brought about the collapse of Niemeyer's theory, which he so vigorously defended, that a primary pulmonary hemorrhage could cause the development of pulmonary phthisis.

In the meanwhile, the period of great bacteriological discoveries came on, and with its coming the existence of a specific organized cause of tuberculosis had to be assumed. Klebs, and later Cohnheim, had already defined tuberculosis as a specific infectious disease, and sooner than was expected the discovery of the specific micro-organism in tuberculous tissues and its etiologic relation to the development of the disease in man and lower animals was made by Robert Koch in 1881. Koch named the organism the tubercle bacillus. His report of the discovery and his work on the subject includes the formulation of his four postulates. The work is a true masterpiece, and so thorough is it that although the first of an inexhaustible amount of literature on the subject, it has not been improved upon to this day.

By an original method of differential staining he succeeded in isolating the tubercle bacillus, and showed its presence in infected areas in all parts of the body. He also demonstrated the absence of tubercle bacilli in other than tuberculous conditions, and even accomplished the successful inoculation of animals from pure artificial cultures of tubercle bacilli. Koch thus established the cause of tuberculosis among man and animals. From that time on the definition of tuberculosis no longer rested on an anatomic basis. Finally, in the discovery of the tubercle bacillus in the "pearly distemper" of cattle, the identity of this disease with tuberculosis, which had been established previously by inoculation, was confirmed

anew. The apparent etiologic identity of all forms of tuberculosis in different species was also determined upon the basis of the characteristic histologic structure of the primary tubercle. Since that time a mass of evidence has been presented by numerous observers, both for and against the acceptance of essential differences in cultural characteristics, virulence and power of transmission of the bacillus in the several animals in which a natural habitat is found. Despite a degree of similarity of the clinical manifestation in different species, important differences, referable to the bacillus of various types, have been noted, and will be the subject of future discussion.

Shortly after his great discovery Koch prepared an extract of dried and powdered tubercle bacilli which, he believed, or hoped, would possess curative properties. He names this extract tuberculin. At first it was eagerly seized upon by the world with the hope that a specific cure had been found, but in this they were doomed to a disappointment, and today tuberculin is chiefly valuable as a diagnostic agent, for it has been found that when this extract is injected into an animal or human being in whom the tuberculous process exists, the fact that the disease exists there is indicated by a characteristic local and systemic reaction. This agent has proved of immense value in detecting tuberculosis in cattle, and has more recently again come into use as a medicinal agent and for diagnostic purposes in man. Koch then prepared "tuberculin R" in his eager search for a cure, but was again unsuccessful.

In 1892 Von Behring startled the entire medical world by announcing that he had discovered a cure for tuberculosis. He never revealed the nature of his supposed cure, and it is very probable that he satisfied himself of its inefficiency before publishing his results, as nothing more was ever heard of it.

From the most ancient times tuberculosis had been regarded as a hopelessly incurable disease, and it has been in only comparatively recent years that belief in its curability has become general. The fact that it is rarely congenital in origin has also been proven by a great deal of experimental work.

The question of whether the human being could be infected by the bovine type of tubercle bacillus naturally arose, and was for a long time the subject of a very heated discussion. Koch believes that each type is pathogenic only for the animal in which it makes its normal habitat, but it is very

probable that on this point he made his first serious mistake, as almost the entire profession is of the opposite opinion.

In view of the more recent and accurate knowledge concerning the disease, many States and Governments passed laws requiring the inspection of cattle for the detection of the disease. Throughout the civilized world an educational campaign has been carried on to aid in the active war which is being waged against that most relentless and most insidious foe of the human race—the tubercle bacillus. Sanatoria are being established everywhere for the segregation of the victims of the "great white plague" and for the cure of the moderately advanced and incipient cases. Millions of dollars are being spent in this good cause, and already very good results have been achieved, making the outlook for the future very bright.

Tuberculosis formerly caused fully one-seventh of all deaths, but during the last few years its death rate has been materially reduced, the decrease in some places amounting to nearly one-half. Statistics afford only a partially correct idea of its prevalence, for many tuberculous persons die of other diseases, and the lesions are found after death in individuals who did not know they were affected. About 50 per cent. of all human beings are infected at sometime during life, and of these about one-half recover without having become aware of the condition. According to Welch, 90 per cent. of all adults over 40 years of age show active or healed tubercular lesions. Every organ and every tissue of the body is liable to the disease, but the lungs are more frequently attacked than any other structure. Were it not for the great resistance shown by so many in fighting down the malady, the tubercle bacillus would, ages ago, have been the means of depopulating the earth. The old German saying that "every man, at death, has a little tuberculosis" is partly true, for often a latent form of the disease becomes active, and may thus become the actual cause of death.

"Tuberculosis is a preventable disease; tuberculosis is a curable disease," and in these two facts lies the hope of the future. It is mainly by preventive methods, however, that tuberculosis will be reduced to a minimum, or, if we may dare hope so, as completely eradicated from the list of ills that man is heir to as have been typhus and yellow fevers.

## PELLAGRA—AN ABSTRACT.

By JOHN W. ROBERTSON, M. D.,  
Resident Physician, University Hospital.

*Definition.*—Pellagra, or Lombardian leprosy, derives its name from *Pellis*, meaning skin, and *Agra*, meaning rough or seizure. Is characterized by alimentary, cutaneous, nervous and mental disturbances. Appears most frequently in the spring months.

*History.*—First recognized in Spain by Gaspar Cazal about 1750. It was called Pellagra by the peasants of Lombardy in 1771 (rough skin). First described in America by Harris of Atlanta in 1902. The disease is very prevalent in Lombardy and Roumania. In Italy it is estimated that there are 100,000 Pellagrins and 22 special hospitals for treatment of same, while in Roumania there are 50,000 Pellagrins.

*Etiology.*—As yet unknown. The trend of opinion as well as statistics point toward fermented maize or Indian corn as the probable cause. Some claim the green fungus is the cause; others a specific organism. There is, however, a definite relation between those eating musty corn, as the poorer classes, and the prevalence of the disease.

*Symptoms.*—The disease nearly always appears in the early spring months. Thayer divides into two types, and each of these into three main classes of symptoms.

The first, or typhoidal type, occurs suddenly, with fatal termination, "running its course in few weeks with active delirium, fever and uncontrollable diarrhea."

The second, or milder, chronic or recurrent, may last 25 years. As above stated, there are three main classes of symptoms (1) alimentary, (2) cutaneous, (3) nervous and mental.

Beginning with the alimentary tract, we find the mucous membranes and tongue of a fiery red color, marked stomatitis, and often deep ulceration and sealing of the epithelium. There is loss of appetite, "dyspepsia," at times vomiting. Salivation is at times a marked and disagreeable symptom. The diarrhea is uncontrollable and the stools of a peculiar odor. Occurs chiefly in the morning, which is of diagnostic value.

*Cutaneous Symptoms.*—There is noted a peculiar symmetrical involvement of back of hands, dorsae of feet, neck, and at times over the malar region, the latter often meeting in the median line of the face. The eruption has, on account of its peculiar distribution, been likened to a collar, glove and boot. The palms and soles of the feet are never affected.

There are three stages of eruption, according to Stelwagon:

(1.) Congestion or erythema, brilliant red in color, later becoming dark brown.

(2.) Have added scaliness, thickening and pigmentation. Underlying skin partakes of red color, often cracked or fissured. With each succeeding attack pigmentation increases.

(3.) In the third stage there is "tendency toward atrophic thinning." Skin partakes of a thin atrophic appearance, wrinkled, lax and later becoming bluish-red color, often exfoliating in large flakes. At times there may be bullae or pustulous formation. Disappears as winter approaches.

(3.) *Nervous and Mental Symptoms.*—There is vertigo, marked increase in deep reflexes, especially of the lower extremities. Spastic gait. Burning sensation of skin becomes so intense there is hydromania and often drowning by jumping in water. At first there is confusion, loss of judgment and will-power. Apathy, "smile-forgotten face" and disorientation as to time and place.

*Hematology.*—Nothing definite as yet except a fairly constant, though not excessive, reduction both in the number of red cells and hemoglobin per cent. There seems to be a tendency toward microcyte formation. The white cells are claimed to be normal by some, while others hold there is an increase in the mononuclear element. Never a leucocytosis. The bacteriology of the blood is negative.

*Diagnosis.*—This is made from the peculiar boot, glove and collar distribution of the eruption, symmetrical in extent. The red mucous membrane, stomatitis, uncontrollable diarrhea, worse in the morning, with peculiar odor to the stool; lost appetite, "dyspepsia," nausea and marked salivation. The occurrence in spring months. Anemia. The nervous and mental disturbances, such as loss of sleep, apathy, disorientation, "smile-forgotten face." History of poverty and corn-eating.

*Prognosis.*—Lavinder says there are 78 per cent. recoveries if treated early. If allowed to run on for year, is fatal. Some cases last for 25 years.

*Anatomically.*—We find sclerotic changes, especially of the lateral columns of the dorsal cord. Rohrer of Baltimore describes granulomata, especially of the superficial blood vessels of the lungs and brain. Also found in the stomach, intestines, spleen, kidney and uterus.

*Treatment.*—This may be divided into prophylactic and curative. The prophylactic consists in the regulation of the corn diet of the poorer classes in reference to the exclusion of musty corn; providing for proper curing of corn, and the prevention of the illegitimate mixing of known worthless corn with a better class to be shipped to the poorer classes in the South; the establishing of local hospitals as in Italy for the treatment of the disease.

The curative consists of arsenic, atoxyl, quinine and various tonics. Serum obtained from horses recovering from "bling staggers" caused by eating moldy corn has been tried with varying results. Thayer reports a case which was apparently cured by Thyroid extract.

As before stated, the mortality is greatly reduced in proportion to the promptness of diagnosis and early institution of the treatment.

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## PUERPERAL AND LACTATIONAL PSYCHOSES.

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By W. F. SCHWARTZ, M.D.\*

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Directly suggested by the weakening influences of sexual excesses, especially in men, are the exhausting effects of pregnancy and the puerperal state in women. At any rate, they have an equivalent significance with those indulgences which are so dangerous to men, for, among every 100 women admitted to asylums, these conditions as predisposing and accessory causes are operative in 17.8 per cent.

Here, as in all cases where physiologic phases are of etiologic influence in the production of mental disease, predisposition is of great importance.

Fürstner found hereditary predisposition in 61.7

per cent. of his cases of this nature, but Ripping found only 44.2 per cent. This investigator, on the other hand, found that an acquired disposition was an important factor, especially the weakening anti-hygienic influence of factory life, to which the majority of his patients were subject.

Other important predisposing factors besides hereditary predisposition are chlorosis, anemia, frequent and difficult births, long-continued lactation, severe diseases, profuse menses, and anything that weakens the constitution. Puerperal insanity is most frequent (9.2 per cent.) ; next comes that of the period of lactation (5.6 per cent.), and finally the insanity of pregnancy (3.1 per cent.).

I. The insanity of pregnancy occurs usually in the last three months of gravidity. Ripping lays great etiologic stress on the changes in the circulation of the brain (anemia) due to the growth of the uterus, the addition of the placental circulation, as well as on chemic changes in the blood consequent upon gravidity.

The predominance of insanity as an accompaniment of pregnancy in the unmarried is explained by the unfavorable conditions of life that usually affect such persons, as well as by the anxiety about the future that naturally arises in such cases. The form of disease which the insanity of pregnancy takes is usually that of melancholia ; seldom mania.

The rare cases of insanity that develop during the early months of pregnancy are really of short duration and favorable prognosis. The insanity of the later months does not end with parturition, and sometimes passes on into mania. The average duration of the disturbance is about nine months. Relapses are frequent in subsequent pregnancies.

II. Mental disturbances that occur during labor are transitory. They are accompanied by great disturbances of consciousness. Most frequently in such cases states of pathologic affect are observed, especially in the unmarried patients, due to the helpless position, shame at the loss of honor, fright at the signs of approaching labor, and anxiety about the future. Besides, there are states of furious excitement induced by labor pains, with delirium and consequent exhaustion, as well as cases of transitory mania, hysterical and epileptic delirium and eclampsia with delirium.

III. Puerperal Insanity. Its pathogenesis is dark. Etiology indicates predisposing causes, which depend, in part, upon hereditary and neuro-pathic constitution ; in part on chlorosis, anemia,

anomalies of the uterus, the weakening influence of preceding severe physical disease, loss of blood, protracted lactation, frequent births ; in part on the depressing influence of fear of death ; in the cases of the unmarried patients, also on shame and anxiety about the future.

Emotional states, mastitis and other febrile somatic diseases may be called accessory causes. The cessation of the lochia and the flow of milk, which the laity blame so often, are symptoms, not causes of the disease.

In the cases of insanity that occur during the earlier weeks the causes are mainly loss of blood, bad nutrition and diet, emotions, the beginning of lactation, mastitis and inflammation of the uterus and its appendages ; in those cases beginning from the fourth to the sixth week, the causes are disturbances brought about by the recurrence of the menses, especially menorrhagia.

The investigations of Ripping and Schmidt show the great influence of disturbances of nutrition (loss in weight) during the puerperal state, for, from the time of admission to the discharge of certain patients they showed a gain in weight, and the insanity had gradually disappeared with the increase in weight.

Most frequently puerperal insanity begins at any time from the eighth to the tenth day of the puerperal state. It assumes no specific form. Mania is the most frequent form in which puerperal insanity runs its course.

During the first two weeks of the puerperal state we meet cases of transitory mania, puerperal fever with delirium, puerperal fever with the delirium of inanition, and puerperal psychoses (for the most part mania or confusional insanity, less frequently melancholia). The proportion of mania to melancholia in these cases is about 3 to 1.

The mental disturbances that occur in the later weeks of the puerperal state are manias and melancholias.

*Puerperal Mania.*—The prodromal symptoms are sometimes those of melancholic depression, which, however, is but slightly marked and limited to emotional depression and a tendency to weep. In the majority of cases the symptoms are those of maniacal exaltation (restlessness, activity, constant activity of thought, talkativeness, sleeplessness).

The brevity of the prodromal stage as well as the mildness of the symptoms in comparison with analogous cases of non-puerperal insanity is re-

markable. After this prodromal stage has lasted a day or more the acme of intense mania is quickly reached, with a continuous remitting course.

Errors of the senses play a great part in the delirium of puerperal mania. As a rule, they are the first in the series of symptoms, and remain prominently in the foreground.

The prognosis is quite favorable. If the disease ends in recovery, in the majority of cases the patient passes through a stage of stupor which seems to be wanting only in mild cases.

Memory for the events of this stage of severe mental exhaustion is very incomplete. Out of this stage the patient comes to herself either suddenly or gradually.

Puerperal mania has no specific symptoms.

Distinguishing it from non-puerperal mania are the shortness of the prodromal stage and the mildness of the symptoms. In general these cases present severe forms of mania with great disturbances of consciousness.

*Puerperal melancholia*, which is less frequent, is of less favorable prognosis, and it lasts longer than mania before recovery. Deep disturbances of consciousness and the demented coloring of the disease picture in such cases are also dependent upon exhaustion. Schmidt emphasizes the morose, distracted, dreamy, forgetful and senseless condition of the patients, as well as the frequent hallucinations and intercurrent attacks of anxiety.

Puerperal insanity may also occur after abortion when there has been a great loss of blood. It is distinguished, like all insanities induced by acute nutritive disturbances of the brain, by multitudinous errors of the senses. In these cases, too, convulsions are not infrequent. The prognosis is favorable.

*Insanity of Lactation.*—The insanity of nursing women is probably always to be referred to anemia. Difficult confinement and the general and local diseases of the puerperal state have a predisposing influence. Nursing too long and too frequently in proportion to the general strength acts as an exciting cause. Insanity seldom occurs before the third month. The predominating form of disease is mania, less frequently melancholia. The prognosis is not unfavorable, but is less favorable than that of puerperal insanity.

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BY RANDOLPH WINSLOW, M.D., LL.D.

Dr. Alan P. Smith was the son of Prof. Nathan R. Smith and the grandson of Prof. Nathan Smith of Yale College. He was born in Baltimore February 3, 1840. He was not the only son of Prof. Nathan R. Smith, but had an elder brother, Dr. Berwick B. Smith, who was at one time demonstrator of anatomy at the University—a young man of bright promise, whose career was cut short by an early death. Dr. Alan P. Smith was educated at private schools and at Princeton College, and pursued his medical studies under the direction of his father at the University of Maryland, where he received the degree of doctor of medicine in 1861. In 1867 and 1868 he held the title of adjunct professor, and in 1869 was appointed professor of venereal diseases, but resigned the position before the opening of the session. In 1873 he was elected to the chair of operative surgery, made vacant by the retirement of Professor Chisholm from that chair. He held this position but one year, and resigned in 1874. Dr. Smith was not a fluent teacher, and disliked the tedium and burden of the lecture-room. After withdrawing from his professorship, he continued to devote himself for the remainder of his life, until stricken with ill-health, to the care of a large, influential and lucrative practice of both a medical and surgical character. He was widely esteemed also as a consulting physician whose opinion was considered to be sound and conservative in character. He was not an author of wide repute, and, indeed, but seldom committed his thoughts to paper, but he was a surgeon of excellent judgment and skill and of remarkable success. He was especially known, as was his father before him, as a successful lithotomist, and in 1878 reported 52 consecutive operations without a death, and it is said upon the authority of Dr. Nathan R. Gorter that he lost but two cases in 112 operations. For a number of years Dr. Alan P. Smith was undoubtedly the most prominent physician in the city, and remained so until younger men and advancing years forced him to a less conspicuous position. He

\*Read before the Neurological and Psychiatric Section, Maryland Medical and Chirurgical Faculty, December 19, 1908, by William F. Schwartz, M.D., 1209 North Caroline street, Assistant in Neurology, University of Maryland.

was a trustee and consulting surgeon of the Johns Hopkins Hospital and of numerous other hospitals and institutions of the city. Dr. Smith was of medium height and of handsome features, and was known for his modesty and amiability. He wielded a large influence in the city and State for many years. He died at his home on Franklin street, near Cathedral street, on July 1, 1898, aged 58 years. Two of his sons followed in his steps as physicians—Dr. Nathan Ryno Smith, who is still a practicing physician in this city, and Dr. Walter P. Smith, who died while still young. As has been stated, Dr. Smith but seldom contributed to medical literature. His most important paper was read at the annual meeting of the Medical and Chirurgical Faculty of Maryland in 1878, and was published in the *Transactions* of the Faculty of that year. This was the report of 52 consecutive operations of lithotomy without a death, a feat perhaps unsurpassed in this country up to that time. Amongst these cases was that of a middle-aged man who possessed a double penis, with two separate bladders. He was suffering with symptoms of stone. He could void his urine at will from either bladder, and the flow from one urethra was clear and healthy, whilst from the other it was foul and ammoniacal. A sound detected a calculus in the bladder from which the purulent urine flowed, which was successfully removed. Curiously enough, Dr. A. F. Erich presented the report of a case of double vagina at the same meeting. Dr. Smith attributed his success as a lithotomist to the use of the lithotome devised by his father, Prof. Nathan R. Smith.

## ITEMS

Dr. T. A. Ashby, who has been a member of the General Assembly of Maryland for the past 90 days, has resumed his professional work and duties in connection with the University of Maryland. Dr. Ashby found his legislative duties so pressing that he was forced to turn over the larger portion of his work in didactic teaching to Dr. J. M. Hundley. The following press notices show what he has been able to do as a lawmaker:

### ASHBY IN THE HOUSE.

In the House one man stands out pre-eminently, and he, strange to say, is not a politician, not the underground schemer, but the independent and

fair-minded Dr. Thos. A. Ashby, of Baltimore city. He has shown strikingly what a man of energy, kindness and purpose, combined with absolute integrity, can accomplish. Practically all of the bills which he introduced—the pure-food law, the lunacy measures, those adding additional powers to the State Board of Health and various other measures—went through so easily that one who did not see the guiding hand of the doctor might have imagined that these things worked themselves. One of the best and most intelligent workers for the city's interests at Annapolis was Dr. Ashby. The doctor has served the further excellent purpose of proving that the politicians don't know it all when they insist that a man who hasn't been to the Legislature and "doesn't know the ropes" can't do any good there. Possibly not—for them.—*Baltimore News*.

### A HINT WHICH BALTIMORE OUGHT TO TAKE.

The excellent record of Dr. Ashby at Annapolis is an object-lesson which Baltimore badly needs. Dr. Ashby is not a politician, and had no experience in the Legislature; yet it is generally agreed that he was one of the most helpful men on the city delegation. If, instead of permitting the politicians to select men who will obey their orders—under the pretext that we must have representatives at Annapolis who are "trained in legislative work"—the people of Baltimore, when time to nominate comes around, would pick out their own representatives, choosing men of substance and character, insisting that they make the necessary sacrifice for the good of the public, it ought to be an easy matter to have a dozen or more men of the right kind in the delegation. It would be hard to overestimate the good effect upon general legislation a score of high-grade men on the city delegation would have, and it is encouraging to learn that it is not necessary for men of that sort to go through a case of sprouts before they can make their influence for good felt.—*Baltimore News*.

### DR. ASHBY THERE ALL THE TIME.

Of Dr. Thomas A. Ashby too much cannot be said in his praise. Going to the Legislature at great personal sacrifice, Dr. Ashby was absent only part of one evening, while both his work and his influence were for the very best interests of the city and the State. To his determined stand is due the fact that the pure-food bill passed without serious mutilation, and that similar measures went

through; on the other hand, he did much toward defeating the anti-vaccination movement and preventing other obnoxious legislation.—*Baltimore Sun.*

Dr. Louis M. Allen, associate professor of obstetrics in the University of Maryland, delivered an address before the recent meeting of the Baltimore County Medical Society. Amongst our graduates who attended the meeting were: Drs. James H. Jarrett, R. C. Massenburg, Josiah S. Bowen, A. L. Wilkinson of Raspeburg, Henry A. Naylor of Pikesville and J. Roston Green of Towson.

At the last regular meeting of the University of Maryland Medical Association, held Tuesday, March 15, 1910, in the amphitheater of the University Hospital, the program was as follows: 1. Report of a series of typhoid cases, Dr. Long, assistant resident physician. 2. Technic and significance of Wasserman reaction, Dr. Hirsh.

The last meeting of the adjunct faculty of the medical department of the University of Maryland was held Wednesday, March 18, 1910. Matters of interest and importance were discussed. The committee in charge of the revision of the schedule made a tentative report. They were ordered to have their recommendations put into printed form, so that those interested could the more readily study the proposed changes.

Dr. R. R. Norris, class of 1904, of Crisfield, Md., was left \$10,000 by his father, who died recently.

Drs. Harry E. Jenkins and Willard J. Riddick, both graduates of the medical department, have been commissioned assistant surgeons in the United States Navy. During the past year these gentlemen attended the Naval Medical School, Washington, whence they were graduated Thursday, March 24, 1910.

Dr. F. O. Miller has been elected secretary of the Howard County Medical Society.

Dr. William Gambrill has been elected a member of the Board of Censors of the Howard County Medical Society for the ensuing year.

Dr. Joshua W. Hering of Westminster, and

Comptroller of the State of Maryland, celebrated his seventy-seventh birthday March 8, 1910. Dr. Hering is one of our oldest living alumni, being a member of the class of 1855. He has led a very active life, and during his career has held many offices of trust, both private and public. His face is still ruddy, and his complexion shows evidence of robust health. Last fall Dr. Hering was rewarded by his alma mater with the degree of LL.D.

Dr. Benjamin R. Ridgely, 86 years of age, of Warren, Baltimore county, is ill with pneumonia. Only recently Dr. Ridgely was nearly asphyxiated with coal gas, but had apparently entirely recovered his usual health.

Dr. Patrick F. Martin is State president of the Hibernians.

Dr. John S. Fulton read a paper, "Source of Infection of Tuberculosis," Thursday, March 10, 1910, before the Baltimore City Medical Society.

Dr. George H. Steuart of Virginia, formerly medical superintendent of the University Hospital, visited the hospital Saturday, April 2, 1910.

Dr. Howard E. Ashbury, radiographer to the University Hospital, read a paper on "The Location of the Stomach by the Roentgen Method as an Aid in the Diagnosis of Obscure Abdominal Conditions" (illustrated) before the Friday, April 1, 1910, meeting of the Baltimore City Medical Society, held at the Faculty Hall.

Dr. John C. Hemmeter, professor of physiology in the University of Maryland, addressed recently the Medical Society of Greater New York at the Academy of Medicine. While in New York Dr. Hemmeter was the guest of Dr. and Mrs. Thomas E. Satterthwaite, 7 East 80th street. Dr. Satterthwaite delivered a course of lectures on the heart to our students in the fall of 1908, and at the same time was a recipient of the honorary degree of LL.D. from our institution.

Dr. R. A. Shankwiler, class of 1900, is physician in charge of the Hazelwood Sanatorium, Louisville, Ky. Before going to his present charge Dr. Shankwiler was assistant resident physician at the Endowood Sanatorium, Towson, Md.

Dr. Jacob Bird, a former assistant resident surgeon in the University Hospital, is located at Sandy Spring, Md., where he has taken the practice of the late Dr. Roger Brooke, class of 1887, also a graduate of the medical department of the University of Maryland.

Dr. William Joseph Coleman, class of 1908, has been appointed an assistant resident surgeon in the University Hospital, vice Dr. Granville Hampton Richards, class of 1908, resigned to enter on the practice of his profession at Port Deposit, Md., where he takes the practice of Dr. H. E. Clemson, 1894, deceased.

Dr. Francis E. Jamison, class of 1907, of Calvert county, Maryland, was a recent visitor to the University Hospital.

Dr. William T. Howard, professor of pathology in Western Reserve University, Cleveland, O., delivered an address on "the value of co-operation between medical, sociological and commercial organizations in the development of municipal hygiene and sanitation in Cleveland" before the Baltimore City Medical Society, Thursday, April 7, 1910.

Dr. J. A. Shakashiri, class of 1909, is located at Anfeh (Al-Koura), Lebanon, Syria, where he is successfully engaged in the practice of his profession.

Dr. George S. Hanna, class of 1901, is practicing his profession very successfully at Tanta, Egypt.

Dr. W. K. Skillman and Dr. G. Latrobe Ewalt were guests at a pill party given by Dr. I. L. Fetterhoff of Baltimore.

Dr. John Whitridge Williams, professor of obstetrics in the Johns Hopkins University, read a paper on "Oliver Wendel Holmes, and the Doctrine of Contagiousness of Puerperal Fever," before the Book and Journal Club of the Medical and Chirurgical Faculty, March 31, 1910.

Dr. Joseph T. Smith, associate professor of hygiene and medical jurisprudence in the University

of Maryland, read a paper at the March 31, 1910, meeting of the Book and Journal Club at the Faculty Building on "The Life of Dr. Elisha Perkins."

Dr. Joseph T. Smith presented recently a set of Perkins tractors to the Medical and Chirurgical Faculty.

Dr. P. S. Rossiter, surgeon, United State Navy, has been detached from the naval station, Tutuila, Samoa, and ordered home to await orders.

Dr. Henry McKee Tucker, class of 1899, a former assistant resident physician in the University Hospital, is located at Raleigh, N. C.

Dr. John I. Pennington of the Marlborough Apartments, Baltimore, was slightly injured recently by having his automobile hit by a work car of the United Railways on North avenue, near Eutaw Place. The machine was considerably damaged, and we are glad to report that the doctor got off with a rather severe shaking up and a few scratches.

Dr. A. W. Goodwin of Raleigh, N. C., has instituted suit in Wake County Superior Court for damages against Dr. J. D. Whitaker. The suit arises out of charges of unprofessional conduct preferred against him before the Wake County Medical Society, as a result of which he has been dropped from the roll of membership. It is claimed that Dr. Whitaker was the chief prosecutor against Dr. Goodwin, for which reason Dr. Goodwin entered suit against Dr. Whitaker. The unprofessional conduct consisted in wilfully making an improper diagnosis so as to prolong his service and inflict a large bill for the services rendered.

Dr. S. R. Edwards of Siler City, N. C., has been elected medical superintendent of the Presbyterian Eye, Ear, Nose and Throat Hospital, Baltimore.

Drs. T. Marshall West and R. B. Hayes, both former internes of the University Hospital, Baltimore, have jointly leased St. Luke's Hospital, Fayetteville, N. C. Dr. Hayes until recently practiced his profession in Baltimore. Dr. West has just completed two years as assistant resident surgeon in the University Hospital. Both these gen-

lemen have left for their new field of labor, and their many friends in Baltimore wish them much success.

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Dr. H. E. Ames, medical director, United States Navy, has been ordered to command of the Naval Hospital, Puget Sound, Washington.

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The fund for the establishment of a lectureship at the Medical and Chirurgical Faculty, in honor of the late Dr. Isaac Ridgeway Trimble, a graduate of our institution and for many years connected with its teaching force, is now rapidly nearing completion. Dr. W. S. Thayer, one of the committee in charge of the raising of the fund, said:

"My idea is that we should have a \$1000 lectureship triennially. I certainly feel that the public of Baltimore owes to Dr. Trimble a debt of gratitude that should be paid, and I know no better way than this. It has been the custom in Europe to honor noted physicians in this manner, and we have seen something of it in this country. I am glad that the response so far has been so liberal, and I trust that everyone who ever felt the generous impulses and tender care of Dr. Trimble will give a little, no matter how much. The amounts will never be made public."

The committee consists of Dr. L. McLane Tiffany, Dr. Charles O'Donovan, Dr. Hiram Woods, Dr. Frank Martin, Dr. W. S. Thayer, Dr. John Ruhrhah and Messrs. Oscar G. Murray, Alexander Brown, Lawrason Riggs and John C. Daves.

Subscriptions to the endowment may be sent to Messrs. Alexander Brown & Sons or to Dr. Thayer.

Dr. Trimble died February 23, 1908, at St. Joseph's Hospital of blood poisoning, which he contracted by cutting a finger of his left hand whilst operating on a patient for pus kidney. His death was deeply deplored both by the profession and by his many friends in the city and State. For many years he was surgeon-in-chief to the United Railways, and also surgeon to the Baltimore & Ohio Railroad Co. In this way his name became known to thousands. That he had done a great work here was generally recognized, and the irony of his death while working to save the life of a charity patient evoked universal sympathy for his afflicted family.

Dr. Trimble was for many years a lecturer in the University of Maryland, of which institution he was a graduate. His later educational efforts were spent as professor of anatomy and clinical surgery in the College of Physicians and Surgeons, Baltimore, where he was much beloved by the student body. He was graduated from the medical department of the University of Maryland with the class of 1884. He was born in Wye House, Talbot county, Maryland, and came of distinguished parentage. Another evidence of the mark of esteem with which his colleagues and friends held him is the memorial operating-room which has just been opened at St. Joseph's Hospital in his honor.

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Crazed from the effects of liquor, Nicholas Leary, a butler in the home of Mrs. Elizabeth Carman, whilst serving dinner suddenly became maniacal Tuesday, April 4, 1910, stabbed Mrs. Carman in the chest, slashed her daughter, Miss Carrie Carman, over the eye, gashed Mr. Stanley Carman, her son, in the abdomen and slightly wounded a guest, Mr. Matthew Donavin. Mrs. Carman is the mother of Dr. Perry Carman, class of 1901. It is reported that her condition is exceedingly critical.

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Miss Nancy Walton, a graduate of the University Hospital Training School for Nurses, has been confined to her home in Annapolis, Md., for some time with a severe tonsilitis.

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We are glad to report to the many friends of Dr. Thomas C. Bussey, a prominent physician of Texas, Md., who was recently stricken with paralysis, that he is in a slightly improved condition. Dr. Bussey is widely known throughout Baltimore county.

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Dr. William D. Hammond, class of 1908, of Hagerstown, Md., a former assistant resident gynecologist in the University Hospital, who had a gastro-enterostomy made on him recently, has recovered sufficiently to be about again.

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Amongst our alumni residing in Baltimore are:  
Doctors—

John R. Abercrombie, 827 N. Eutaw street.  
J. Fred Adams, 1314 N. Charles street.

- Harry Adler, 1804 Madison avenue.  
 Carl H. Ahroon, 3020 E. Baltimore street.  
 Harry C. Algire, 340 Roland avenue.  
 Louis M. Allen, 814 Park avenue.  
 Harry H. Arthur, 1516 W. Lexington street.  
 Howard E. Ashbury, 1029 Cathedral st.  
 Thomas A. Ashby, 1125 Madison avenue.  
 Caleb N. Athey, 3202 Hudson street extended.  
 A. Duval Atkinson, 921 N. Charles street.  
 Silas Baldwin, 700 W. Lexington street.  
 Edwin Kemp Ballard, 1622 Mt. Royal avenue.  
 Robert Parke Bay, University Hospital.  
 Samuel J. Belt, 1516 E. Preston street.  
 Henry J. Berkeley, 1305 Park avenue.  
 Charles F. Bevan, 807 Cathedral street.  
 Hamson H. Biedler, 119 W. Saratoga street.  
 Joseph Blum, 1816 Madison avenue.  
 John Henry Bolton, 1201 N. Broadway.  
 Allen Kerr Bond, 849 Park avenue.  
 James Bordley, 330 N. Charles street.  
 Wilmer Brinton, 1232 N. Calvert street.  
 Francis E. Brown, 917 St. Paul street.  
 Bennett Bernard Browne, 510 Park avenue.  
 Charles Teakle Buckner, 1337 E. North avenue.  
 William Baltzell Burch, 828 N. Carrollton ave.  
 George Henry Cairnes, 21 W. 25th street.  
 T. Harris Cannon, 401 N. Fulton avenue.  
 Richard Perry Carman, 1701 N. Caroline street.  
 Francis A. Carpenter, Bellevue-Manchester.  
 Albert H. Carroll, "Evergreen," Hampden.  
 James Joseph Carroll, 330 N. Charles street.  
 Walter S. Carswell, 2 West 25th street.  
 Frederick Caruthers, 330 N. Charles street.  
 A. T. Chambers, 614 S. Paca street.  
 Samuel C. Chew, 3 Midvale road, Roland Park.  
 William P. Chunn, 1023 Madison avenue.  
 Sydenham Rush Clarke, 330 E. 25th street.  
 Charles Carlisle Conser, 1424 N. Fulton avenue.  
 Theodore Cooke, 914 N. Charles street.  
 Theodore Cooke, Jr., 1808 N. Charles street.  
 Eugene F. Cordell, 257 W. Hoffman street.  
 James M. Craighill, 1730 N. Charles street.  
 Martin John Cromwell, 330 N. Charles street.  
 J. Frank Crouch, 412 Cathedral street.  
 Nicholas Leeke Dashiell, St. Paul street.  
 H. Cook Davis, 114 W. Franklin street.  
 Samuel G. Davis, 1230 Light street.  
 George W. Dobbin, 56 W. Biddle street.  
 Eugene Douglas, 830 W. North avenue.  
 Samuel T. Earle, 1431 Linden avenue.  
 Page Edmunds, 1513 Edmondson avenue.  
 Emanuel W. Eilau, 1908 Madison avenue.  
 George A. Fleming, 1018 Madison avenue.  
 John S. Fulton, 2211 St. Paul street.  
 J. William Funk, 1631 Eutaw Place.  
 Carey B. Gamble, Jr., 26 W. Biddle street.  
 Joseph E. Gately, 111 S. Broadway.  
 Frank D. Gavin, 16 E. Lafayette avenue.  
 Edward E. Gibbons, 1102 W. Lafayette avenue.  
 Joseph E. Giehner, 1516 Madison avenue.  
 Leo J. Goldbach, 2217 E. Pratt street.  
 Nathan Ryno Gorter, 1 W. Biddle street.  
 John H. Grimes, 114 E. 21st street.  
 Harry Gross, 909 Cathedral street.  
 Henry J. Hahn, Irvington.  
 William S. Hall, 716 Park avenue.  
 George H. Hammerbacher, 835 Light street.  
 Herbert Harlan, 516 Cathedral street.  
 A. C. Harrison, 31 E. North avenue.  
 Jacob H. Hartman, 5 W. Franklin street.  
 John F. Hawkins, 1608 S. Light street.  
 George W. Hemmeter, 800 Harlem avenue.  
 John C. Hemmeter, 1734 Linden avenue.  
 E. H. Henning, 2000 Hollins street.  
 Frederick H. Herrmann, 3115 E. Baltimore st.  
 Jose L. Hirsh, 1819 Park avenue.  
 Joseph W. Holland, 1624 Linden avenue.  
 Joseph G. Hollyday, 714 Frederick avenue.  
 B. Merrill Hopkinson, 330 N. Charles street.  
 August Horn, St. Paul and 25th streets.  
 John Houff, 15 N. Monroe street.  
 J. Mason Hundley, 1009 Cathedral street.  
 J. Howard Iglehart, 539 N. Carrollton avenue.  
 N. E. B. Iglehart, 16 W. Preston street.  
 Joseph L. Ingle, 1007 W. Lanvale street.  
 F. W. Janney, 327 N. Charles street.  
 O. Edward Janney, 825 Newington avenue.
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Rezin Warfield Hall, class of 1874, of Moundsville, W. Va., is a prominent physician of Marshall county. He is a native of Carroll county, Maryland, where he was born November 6, 1844. He is a son of William Hall and Rachel Airey Molineaux Hall, and comes of distinguished New England ancestry. Dr. Hall received his preliminary education in private schools, his collegiate at the University of Ohio, and a business course at the Capital City Business College, Columbus, O. In 1862 he enlisted as a pri-

vate in the Sixth West Virginia Volunteer Infantry, and was mustered out of service as quartermaster sergeant April 4, 1865. In 1872 he matriculated in the medical department of the University of Maryland, whence he was graduated with the class of 1874. Immediately after graduating he located in West Virginia, where he has ever afterwards practised his profession. On July 13, 1869, Dr. Hall married Mary Ellen Erwin, by whom he has had four children, Bertie Leona, Rosa Bell, deceased; William Edgar, deceased, and Evangeline Hall.

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Drs. Randolph Winslow and R. Dorsey Coale were members of the committee of arrangements of the Association of American Medical Colleges, which met in Baltimore recently.

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Dr. Eugene F. Cordell delivered the annual address before the Pennsylvania Branch of the General Alumni Association at their recent meeting at Lancaster, Pa.

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Dr. W. Cole Davis, class of 1908, is attending the Army Medical School, Washington, D. C.

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Dr. Guy Walter Latimer, class of 1901, is located at Hyattsville, Md.

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Dr. Jesse Oliver Purvis, class of 1904, is located at Annapolis, Md.

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Dr. Louis B. Henkel, Jr., class of 1903, one of the most prominent and aggressive members of the medical profession in Anne Arundel county, Md., was born in Jersey City, N. J., April 18, 1881. His early education was obtained in a private school and his higher education at St. John's College, Department of Arts and Sciences, University of Maryland, Annapolis. After graduating from St. John's, he took up the study of pharmacy under the instruction of Dr. C. B. Henkel of Annapolis, and later entered the Maryland College of Pharmacy, now the Department of Pharmacy, University of Maryland, and was graduated Ph.G. in 1900. He matriculated in the Medical Department of the University of Maryland in 1900 and graduated therefrom in 1903. Soon thereafter Dr. Henkel engaged in active practice at Annapolis, Md., where he is at present located, and during the brief period of his career

has become a prominent character in the professional, social and political circles of that city. In 1904-1905 he was city health officer, and now is a member of the visiting staff of the Emergency Hospital, Annapolis. He is a member of the council of the Maryland Society for the Prevention and Relief of Tuberculosis, and in April, 1905, was a delegate to the American Anti-Tuberculosis League at Atlanta, Ga.

He is a member and reporter of the American Medical Association, member of the Medical and Chirurgical Faculty of Maryland, secretary of the Anne Arundel County Medical Society, member of the Maryland Pharmaceutical Association, the Alumni Association of the Medical Department of the University of Maryland, the University of Maryland General Alumni Association, the Alumni Association of the Maryland College of Pharmacy, the Business Men's Association of Annapolis, medical examiner of the Baltimore Life Insurance Co., physician and examiner for the Fraternal Order of Eagles, secretary for the Anne Arundel County Branch of the Maryland Association for the Prevention and Relief of Tuberculosis, and a member of the board of medical examiners of Maryland. Dr. Henkel is married.

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Dr. Edward J. Bernstein was born at Baltimore August 25, 1863. He was graduated from the Maryland College of Pharmacy, now the Pharmaceutical Department of the University of Maryland, in 1884, with the degree of Ph. G., and from the Medical Department of the University of Maryland in 1887. He was resident physician at the Hebrew Hospital, Baltimore, 1887-1889; oculist and aurist to Bayview Hospital and House of Refuge, laryngolist to the Hebrew Hospital, clinical lecturer on the nose and throat, and clinical professor of eye, ear, nose and throat diseases, Woman's Medical College of Baltimore, 1898-1900. About five years ago Dr. Bernstein moved to Kalamazoo, Mich., where he has established himself in his specialty. Dr. Bernstein is a friend of the University of Maryland and is interested both in its educational and financial prosperity. He came East to attend the centennial exercises. The BULLETIN is glad to assure his friends that he has succeeded above all expectations in his new location and has become a thorough Westerner.

Dr. Summerfield Berry Bond, class of 1883, formerly clinical Professor of Genito-urinary Diseases in the University of Maryland, and now head of the relief department of the Baltimore & Ohio Railroad, practiced medicine in Baltimore for more than 20 years, only discontinuing after assuming the directorship of the Baltimore & Ohio medical department. He was born in Baltimore April 9, 1861, and is a son of Hugh Lennox and Annie G. Pennington Bond. He was educated in private schools, Philips Exeter Academy, New Hampshire, and the medical department of the University of Maryland, from which institution he was graduated in 1883. He later took post-graduate work at the Johns Hopkins University and in the institutions of Paris. From 1884 to 1886 he was Chief of Clinic to the Professor of Surgery, University of Maryland; Chief of Clinic of the Genito-urinary Department of the University of Maryland, 1898-1901, and from 1901 until 1908, when he resigned, First Associate Professor, then Clinical Professor of Genito-urinary Diseases. Dr. Bond married Miss Julia B. Valentine, and has two children—Lydia Valentine and Julia Valentine Bond.

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Dr. J. W. McSherry of Martinsburg, W. Va., is one of the oldest and most successful of the alumni of the University of Maryland now engaged in active practice. Dr. McSherry graduated in the class of 1855. In a recent letter to the editor he writes: "I believe in the University of Maryland. When I studied medicine we had only six professors; no laboratories and all such." Dr. McSherry is now 76 years old, and still active and enterprising in his work. He has been a most successful physician and is devoted to country work. He owns a number of valuable farms in Berkeley county, to which he gives much attention. Few men are as much beloved as Dr. McSherry, as his benevolence, kindness and usefulness are known far and wide among his people.

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Amongst our warrior alumni, the BULLETIN desires to call attention to the late Lennox Birkhead, class of 1817. He was born at Cambridge, Md., February 27, 1794, and was a son of Solomon Birkhead. He received the degree of B.A. from Dickinson College (1813) and was a defender of Fort McHenry (1814). He was the author of "A Voice From the South" (Baltimore,

1861). Died at Baltimore of Bright's disease September 2, 1865. It is indeed interesting to note the number of our alumni who have served their country in time of war.

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Dr. Edward Murray McComas, of Washington, D. C., and a member of the class of 1873, has been engaged in the practice of his profession for 37 years. He is a native of Hagerstown, Md., and was born November 30, 1851. He is a son of John E. McComas and Elizabeth S. Murray, his wife, and is of American descent.

His earlier education was obtained in the public schools of his native State and Hagerstown Academy, and his higher at Franklin and Marshall College, Mercersburg, Pa. He received his medical training at the University of Maryland Medical Department, where he matriculated in 1870 and was graduated with the degree of M.D. in 1873. Since that time he has engaged in general practice, his present location in the city of Washington being 1406 I street N. W. Dr. McComas is a member of the Presbyterian Church. He married, February 1, 1883, Florence Andrews.

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Dr. John R. Benton was born at Kent Island, Queen Anne county, Md., September 3, 1858. He was educated at the State Normal School and taught in the public schools three years. He received his medical degree at the University of Maryland in 1883. He practices at Kent Island, Md.

## MARRIAGES

Dr. E. Harold Willard, class of 1908, of Mt. Pleasant, Md., and son of Mr. C. F. Willard, of the same place, was married recently at Knoxville to Miss Mary Louise Gittings, daughter of William Gittings of Knoxville. Rev. E. C. Smith was the officiating clergyman. Dr. and Mrs. Willard will reside at Mt. Pleasant, near Frederick, Md., where Dr. Willard is engaged in the practice of his profession.

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Dr. Robert S. Page, class of 1898, of Belair, Md., was married recently to Miss Grace Rogers Streett, daughter of Mr. Joseph M. Streett. The ceremony took place in Emmanuel Protestant Episcopal Church, Belair, Rev. Dr. John I. Yellott officiating.

## DEATHS

Dr. Harry E. Clemson, class of 1894, a prominent physician of Port Deposit, Md., died at his home suddenly March 21, 1910, of heart disease. Since the flood of January 23 Dr. Clemson has been overworked, to which his illness is attributed. He, with his wife and aged mother, were rescued from the roof of their porch. Dr. Clemson was 43 years of age, and is survived by his wife and mother. He was a son of the late Oliver P. Clemson, and was born in Elkton. His preliminary education was obtained in local schools, his literary at Delaware College, from which he was graduated. He attended the medical department of the University of Maryland, whence he received the degree of Doctor of Medicine with the class of 1894. After graduating he first located in Elkton, Md., but later removed to Port Deposit, where he succeeded in building up a large practice. He was a member of the Cecil County Medical Society and the Odd Fellows. Interment was at Elkton.

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Dr. Edward Wootton, class of 1861, 70 years of age, and for many years a leading physician of Montgomery county, died about 9 o'clock April 1, 1910, at his home in Poolesville, of pneumonia. He was ill only two days. About three years ago Dr. Wootton suffered a stroke of paralysis, since which he has had several more, as a result of which he had been confined to his home for the past year. Dr. Wootton obtained his literary education at Georgetown University. He matriculated in the medical department of the University of Maryland in 1860, whence he was graduated with the degree of Doctor of Medicine in 1861. After graduating he returned to Poolesville, where he had since lived. About 10 years ago his health failed, and he was forced to forego the practice of his profession. He served through the Civil War as surgeon in Col. E. V. White's battalion of Confederate Cavalry. From 1889 to 1893 he represented his county in the State Senate as a representative of the Democratic party. He also served two terms in the House of Delegates. Besides his widow, who was before her marriage Miss O'Rhea of Fauquier county, Virginia, he is survived by the following children: Messrs. Norman, Roland and Albert Wootton and Mrs. Thomas F. Chiswell, all of Montgomery county, Maryland, and

Dr. Turner Wootton, class of 1899, and Hartley Wootton of Hot Springs, Ark. Dr. Wootton was born near Rockville, and was the son of the late Dr. Turner Wootton, class of 1819, a prominent physician of his day and generation.

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Dr. Harry J. Boyd, class of 1888, of Belair, Md., died in the Union Protestant Infirmary, Baltimore, February 14, 1910, three weeks after a surgical operation, aged 41.

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Dr. Charles C. Benson, class of 1883, lately of Philadelphia, died Saturday, March 18, 1910, by suicide, aged 73.

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Dr. Hector H. Goodman of 1404 Madison avenue, Baltimore, Md., died Sunday, March 20, 1910, following an operation for a nasal affection. Dr. Goodman's death was a great shock to his family and friends, as his condition was not considered serious. Death was due to meningitis. Dr. Goodman was a member of one of the oldest families of Maryland. He was born at Annapolis, and received his early education in that city. He graduated from St. John's College, and succeeded his father in the drug business in his native city. In the early seventies he came to Baltimore and matriculated in the medical department of the University of Maryland, whence he was graduated with the class of 1875, and immediately entered upon the practice of his profession in Baltimore. Dr. Goodman was successful from the commencement of his career, and soon built up a large and lucrative practice. He was for three years a police surgeon. For the past 25 years he was connected with the medical department of the Baltimore Life Insurance Co. He is survived by his widow, Mrs. Dorrie A. Goodman, five brothers and a sister. Interment was in Loudon Park Cemetery. The funeral arrangements were in charge of the Masonic Order, of which Dr. Goodman was a member.

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Dr. Greenbury Linton Shipp, class of 1885, of Little Hocking, O., died suddenly in that city January 3, 1910, from heart disease, aged 47.

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Dr. Charles S. Kerr, class of 1868, died at his home in Kerr, N. C., March 6, 1910, aged 65.

# THE HOSPITAL BULLETIN

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Vol. VI

BALTIMORE, MD., MAY 15, 1910.

No. 3

## GOITRE.

By RANDOLPH WINSLOW, M.D., LL.D.

(Continued from Page 26, Vol. VI, No. 2.)

### CASE 20.—*Exophthalmic Goitre (Cured).*

Mrs. S. G.; admitted September 17, 1907; discharged October 11, 1907.

Patient entered Hebrew Hospital 17th of September, 1907, complaining of "nervousness for the past four years," which prevented her from retaining any permanent position. The present trouble dates from the death of her mother in January, 1904, when she became nervous and suffered from palpitation of the heart. In May, 1904, a physician remarked on her protruding eyes and a small tumor in the patient's neck, which has greatly increased in size since the beginning, but neither the size of the tumor nor exacerbation of symptoms is greater at the menstrual period. Palpitation of the heart, loss of appetite and development of temperature caused the patient to enter the hospital.

A physical examination revealed marked exophthalmos, and the patient was unable to cover the eyeballs with the lids. A diffuse mass, the size of a small orange, was noted on the right side of the median line in the region of the thyroid gland, also a tumor in the same locality on the left side, but only as large as an English walnut. The mass was distinctly outlined and movable. The surface was smooth and firm. A distinct thrill was elicited over the tumor on both sides, and also a sense of pulsation over the carotids. A murmur, dull, but with its greatest intensity over the right upper, outer portion, was heard on auscultation. She suffers from dyspnea and palpitation of the heart, and is easily exhausted on exertion.

Pulse rate 100-135; volume, tension and force good. Has exacerbations of temperature reaching 104° to 105° every third day.

*Operation.*—September 26, 1907. The field of operation was cleansed in the usual manner. Mor-

phia sulphate, gr.  $\frac{1}{4}$ ; atropin, gr. 1-150, was given the patient hypodermically one-half hour before the operation. The line of incision was infiltrated with Schleich's solution, and an incision was made extending from the median line outward toward the right side of the neck over the lower portion of the mass to a point about three and a half inches from the median line. The veins of the neck were then exposed and ligated. The sterno-hyoid and sterno-thyroid muscles were divided and the



CASE XX.

sterno-cleido-mastoid retracted. The capsule, which was very vascular, was then exposed and opened. The right portion of the mass was dissected from the capsule and removed, and the stump sutured. The divided sterno-hyoid and sterno-thyroid muscles were sutured, and the wound was tightly closed. Drainage was secured through a puncture in the skin at the suprasternal notch. During the operation 1-30 gr. strychnine

was given hypodermically, and the patient's condition was good, her pulse registering from 140 to 145 per minute.

Between the time of admittance to the hospital and the operation the patient's mental condition became excited, and her temperature rose to 105°, but her pulse was feeble and rapid. The day following operation her temperature reached 101°, pulse 120 to 140 per minute, both gradually returning to the normal, which was reached on the sixth day.

The exophthalmos decreased and the patient's condition was very satisfactory. Highest temperature after operation 101°, highest pulse after operation 150, highest respiration after operation 29. She subsequently was able to resume her work.

CASE 21.—*Simple Goitre (Cured).*

F. F.; age 21 years; colored; married; admitted to University Hospital March 9, 1908; discharged March 27, 1908.

The patient came to the hospital with a lump in her neck. It was about the size of a hen's egg and toward the right side of neck. The respiration was embarrassed, the pulse quickened and a change in voice noticed. The lump moved when the patient swallowed. She first noticed this lump in the neck about a year before coming to the hospital. A tickling in the throat, resulting in a soreness and followed by coughing, bothered her for some time, but otherwise no suffering was experienced. Exertion caused great shortness of breath, and sleep was secured only when the patient was propped up with two or three pillows. As the lump increased in size the shortness of breath became more pronounced.

*Operation.*—March 12, 1908. Preparation was made in the usual way and a local anesthetic was applied. A transverse incision about three inches in length was made exactly over the center of the thyroid gland. The right lobe was exposed and found very much enlarged. After some difficulty, on account of tight adherence to surrounding structures, it was shelled out with the capsule intact. The vessels were then tied with fine silk, and a small rubber tube was inserted for drainage, after which the wound was closed with catgut sutures. During the operation the patient complained of but little pain, and had no difficulty in breathing. Tube was removed in four days and the suture in 11. On the eleventh day a primary

union had taken place, but the drainage wound was still open. The wound was healed and drainage had ceased when the patient was discharged 16 days after operation.

Highest temperature 101 3/5°, highest pulse 150, highest respiration 35.

CASE 22.—*Parenchymatous and Colloid Goitre (Cured).*

B. M.; age 20; white, unmarried girl; admitted February 23, 1909; discharged March 8, 1909.

The thyroid gland was well defined and hypertrophied, and was movable, but not tender. The enlargement was most marked upon the right side. The development had been going on for four years, but gave the patient no discomfort except when she slept on her back. No exophthalmos or cardiac disturbance had resulted, but she was very nervous.

*Operation.*—Hyocine and morphia were administered hypodermically before the operation and ½ per cent. cocaine solution infiltrated locally. A curved incision was made, with convexity downward, about four inches long. The flap was dissected up, muscles divided and capsule opened. Right lobe and portion of left removed. Some hemorrhage, but no large vessels or nerves cut. Bleeding points ligated, a tube introduced for drainage, muscles and fascia closed with silk. Skin sewed with silkworm gut. Wound dressed with posterior splint of pasteboard to neck. Drain removed on the second day after operation; sutures removed on the sixth day, the wound having healed except at the point of drainage.

Temperature 101°, pulse 115, respiration 30.

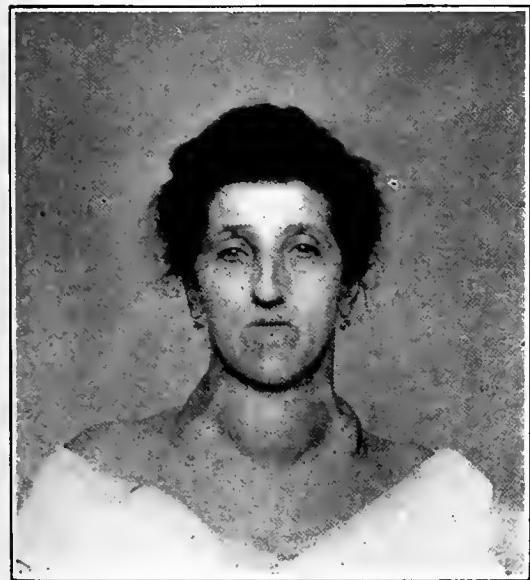
CASE 23.—*Hypertrophied Thyroid, with Enlarged and Inflamed Accessory Thyroids (Cured).*

Mrs. C. K.; age 54; white; formerly one of Professor Czerny's hospital nurses at Heidelberg; admitted March 11, 1909; discharged March 22, 1909. Referred to me by Dr. McElfresh.

About five years before coming to the hospital the patient strained her neck, and soon noticed a swelling in the midline of the neck just above the clavicle. This enlarged, but was painless until a year before operation, when the patient noticed a swelling growing on each side of her neck just posterior to the sterno-cleido-mastoid. About a month before coming to the hospital these began to increase in size, were tender, painful and in-

flamed, and interfered somewhat with respiration. She cannot lie flat, but must be propped on her side. Lips were very cyanotic, but heart was clear; no exophthalmic symptoms; pulse rate slightly accelerated.

*Operation.*—March 12, 1909. Morphia,  $\frac{1}{4}$  gr., and scopolamine, 1-150 gr., were given to the patient, and half an hour later another hypodermic of one-half that strength was given. A local instillation of  $\frac{1}{2}$  per cent. cocaine was administered after the neck had been prepared in the usual manner for an aseptic operation. An oblique incision was made over the lump on the right side about two and a half inches long just back of sterno-mastoid, running obliquely downward and forward, and three separated and detached lumps



CASE XXIII.

were removed. A curved incision, convexity downward, was made over the growth in the median line, and the gland was removed subcapsular; no vessels ligated, but were crushed at base and tied off. The tumor on the left side was not entirely removed, but was sutured through and through with catgut. All three drained freely.

Drains removed on third day, sutures on seventh, and the wound healed nicely. The highest temperature was  $101\frac{3}{5}^{\circ}$ , pulse 112, respiration 30.

This was an exceedingly interesting case, as there were three entirely separate glandular masses behind the sterno-mastoid muscle in the right posterior triangle of the neck, which were removed and found to be thyroidal on microscop-

ical examination. Another distinct growth as large as a hen's egg was found posterior to the left sterno-mastoid muscle, which was partially removed, as it was feared to remove too much thyroid gland tissue, whilst in the center of the neck was a large globular mass over the trachea, which was excised entirely. She made a good recovery.

#### CASE 24.—*Cystic Goitre (Cured).*

Woman; white; age about 35; was admitted to University Hospital in the winter of 1908-09 for some medical or gynecological complaint. She was noticed to have a distinct enlargement of the thyroid gland, nodular, but causing no special discomfort, except that due to its cosmetic effect. She desired to be relieved of the blemish. Operation was done under local anesthetic, the gland exposed, and the growth was found to be a cyst embedded in the substance of the thyroid gland. This was enucleated entire without rupturing the cyst. The cavity from which it came was closed with sutures. No drainage was employed, and she made an absolutely uninterrupted recovery.

#### CASE 25.—*Colloid Goitre (Cured).*

Mrs. H., white, age about 30, was admitted to the Woman's Hospital of Maryland under Dr. Robert T. Wilson for some gynecological trouble. She had also quite a large parenchymatous or colloid goitre, which was causing nervous symptoms, which Dr. Wilson asked me to remove.

*Operation.*—December 3, 1908, under local anesthesia and morphia and scopolamine. Patient in sitting posture. Right lobe of thyroid removed. Drainage provided, and patient made a good recovery in eight days. She had some elevation of temperature for a few days.

#### CASE 26.—*Simple Goitre (Cured).*

Mrs. R.; admitted to University Hospital July 8, 1909.

She is a white woman, 38 years of age, who has been under treatment for various troubles, and is referred to the surgical side on account of a lump in the neck, on the right side, the size of a hen's egg. This is smooth, movable and not tender, and was first noticed about 10 years ago, and has gradually reached its present growth. She complains of stiffness and pain in the neck, but is highly neurotic.

*Operation.*—July 9. Hyoscine, cactin and mor-

phia used hypodermically as an anesthetic, with a weak cocaine solution infiltrated into the skin. She bore the operation without difficulty. The usual collar incision was made, three inches in length. The right lobe of the thyroid gland was removed, a small drainage tube introduced through a separate puncture, and the skin incision sutured tightly. She made an unimpeded recovery.

**CASE 27.—*Adenomatous Goitre, Multiple Adenoma (Cured).***

Mrs. C., white, aged 42 years, admitted to the University Hospital in October, 1909, with a large goitre, the isthmus being especially prominent, and hard to the touch. Under ether anesthesia a large mass was enucleated from the isthmus and a number of smaller ones from the right lobe. The thyroid gland was not sacrificed, bleeding was rather free, but was arrested by suturing the cut surfaces of the gland. Drainage was employed. Patient made an uneventful recovery.

**CASE 28.—*Graves' Disease (Cured).***

Mr. C., about 45 years of age, entered the University Hospital November 25, 1909. He had been suffering for some months with tachycardia and tremor. There was no distinct exophthalmos, but the eyes were somewhat staring, thyroid gland did not appear to be greatly enlarged, pulse varied from 120 to 160. Upon entrance to the hospital pulse 150, but of good tone. After several days' rest in bed, subcapsular thyroideectomy of the right lobe was done, under ether anesthesia. Wound thoroughly drained. After the operation pulse gradually dropped, and when he left the hospital it varied from about 90 to 120. After a few weeks he was able to return to his occupation in a greatly improved condition. When last heard from his pulse was about 85 beats to the minute and his general condition was *good*.

**CASE 29.—*Adeno-cystic Goitre (Cured).***

Annie, colored, about 25 years of age, a very stout, short-necked woman, entered the University Hospital the latter part of November, 1909, with a marked goitreous enlargement of the thyroid gland on both sides, and with a well-marked globular mass in the isthmus. She had shortness of breath and other symptoms of pressure on the trachea. Operation December 1, 1909, under

ether. The usual transverse incision in the neck was made, tumor exposed and a cyst the size of a walnut was enucleated from the isthmus and many adenomatous nodules from both lobes. There was very little hemorrhage; the cut surface of the gland was sutured; no arteries were ligated; drainage was employed. The patient made an uninterrupted recovery.

**CASE 30.—*Adenomatous-colloid Goitre (Cured).***

Miss K. M.; aged 45; white; a stout woman with a short neck, with distinct lump over the trachea, and the left lobe of the thyroid markedly enlarged; nervous, and with pressure symptoms. Entered the University Hospital in January, 1910, and was operated on January 10, 1910. The left lobe and the isthmus were excised within the capsule in the usual manner; drainage employed for 48 hours; ether anesthesia. Patient made a good recovery.

**CASE 31.—*Graves' Disease (Cured).***

Miss O., aged 15, with a large bilateral soft goitre; tachycardia; pulse 120; some tremor; leucocyte count 9500; healthy, ruddy-looking girl; no decided exophthalmos. Duration of disease, about two years, rapidly increasing. Admitted to the University Hospital April 24, 1910. Operated on April 25, 1910, under ether anesthesia; removed left lobe, isthmus and part of right lobe. The capsule did not strip off easily, and there was considerable bleeding. Two small drainage tubes were introduced; there was some difficulty in breathing during the operation, which was found to be due to a collapse of the trachea and to a flattening of this tube from pressure of the goitre. Patient stood the operation well, got off the table in good condition and made a good recovery, the pulse falling to 100 on the second day after operation, and the temperature to normal on the third day.

I have given brief reports of the foregoing cases to show what may be expected from the operative treatment of these distressing, and in many instances, dangerous conditions. At the best, goitre is a hideous deformity, causing discomfort and distress to the sufferer, whilst in a considerable proportion of cases pressure symptoms supervene, or malignant degeneration takes place; and the exophthalmic variety or Graves' disease is frequently a fatal malady under the usual methods of treatment.

AN ADDRESS TO THE MEDICAL CLASS  
OF 1910 IN THE UNIVERSITY OF  
MARYLAND.

By SAMUEL C. CHEW, M.D., LL.D.,  
*Emeritus Professor of Medicine.*

Gentlemen:

I have been very much gratified by your request, received through my friend and colleague, Professor Mitchell, that I would meet you and deliver a clinical lecture before you. Nothing would give me greater pleasure than to accept your invitation if it were possible to do so, and to renew, though only for one short hour, the relations of pupils and teacher which existed between us when, a little more than a year ago, on April 7, 1909, they were almost suddenly broken off. For, when on that day, having just begun the consideration of the subject of peritonitis, I ended my lecture, parted from you and left the lecture hall, I little thought that it would be the last instruction that I should ever give as a professor in the University of Maryland.

The pleasure of meeting you once more and of addressing to you some words of instruction would, I repeat, be great if I were equal to the effort, but I am not, for the staggering blow of the attack of influenza sustained a year ago left me with such impaired strength and such diminished vocal power that the attempt would end in failure.

And yet, I cannot but dwell in imagination upon the pleasure I should have experienced in bringing before you and considering with you some of the nicer problems of differential diagnosis; let us say in the cases of valvular diseases of the heart. And may I flatter myself with the belief that the discussion of these problems, even as conducted imperfectly by myself, would give you pleasure, as I know it does under the skillful guidance of my successor, the present incumbent of the Chair of Medicine.

For, indeed, I know of nothing in the whole range of internal medicine of more absorbing interest than the investigation by the methods of auscultatory diagnosis of the changes wrought by disease in the endocardium, and especially those parts of the endocardium which enter into the structure of the cardiac valves.

When it is considered that portions of three of these four valves lie beneath an area drawn upon the surface of the chest of hardly more than a

square inch, it would seem to one knowing nothing of the methods to be employed simply impossible to ascertain the changes that have taken place in any one or two or three or all four of these valves; to learn the nature, the situation and the consequences of these changes, and in many cases the means for obviating their effects. And yet, as you well know, these problems may be solved with the precision and accuracy of mathematical propositions through the methods first shown by the genius of one great physician—René Theodore Laennec, who was not only a brilliant light of science, but a humanitarian who wrought good for millions of mankind.

Or, again, let me refer for a moment to the physical changes and the methods of diagnosticating them in that most interesting malady, pulmonary emphysema, for a knowledge of which we are also indebted to Laennec. Of this contribution to pathology, Rokitansky said that had Laennec done nothing else than show the true nature of emphysema, that alone would have been enough to make his name in science immortal.

Of the 45 years in which I was a teacher in the Medical School of the University of Maryland, 24 were largely occupied in studying such problems as these and in instructing my successive classes in them, and I look back with pleasure to the time so spent.

Of these classes you, gentlemen, the graduates of 1910, are the last. For this reason I regard my relations with you and the year in which I taught you as constituting an epoch in my connection with this school.

In taking leave of you let me say these farewell words: Look upon your professional calling, both as regards what it has accomplished in the past and what it is sure to achieve in the future, much of which you yourselves may witness, and part of which at least I trust you may contribute to, as a calling high among the highest. Devote yourselves faithfully to it. Make it, each one of you, your constant effort to attain in it the greatest proficiency of which you are capable. Remember that it is a noble service of humanity; that it is not a money-getting trade, and, therefore, resist the spirit of commercialism which sometimes seems to beset it.

And let it be  
“Enough, if something *from* your hands have  
power,  
To live and act and serve the future hour.”

CONTINUATION OF ARTICLE ON  
TRAINING OF MEDICAL STUDENTS  
FOR OBSERVATION AND RECORD-  
ING OF CLINICAL CASES.

By J. C. HEMMETER, M.D., Ph.D., etc.

A CASE OF GASTROPTOSIS AND NEU-  
ROSIS. PREPARED FOR THE CLINIC  
OF PROF. J. C. HEMMETER, M.D., LL.D.

By C. N. DEVILBISS, *Cand. Med.*,  
and  
A. C. McCALL, *Cand. Med.*

University Hospital, January 26, 1910.

*Name*—Mrs. R. L.

*Age*—Thirty-one years.

*Occupation*—Housewife.

*Social Condition*—Married.

*Sex*—Female.

*Race*—Caucasian. Anglo-Saxon.

*Present Address*—Baltimore, Md.

*Chief Complaint*—Dyspepsia and nervousness.

*Family History*—Father died at age of 60 years; cause, alcoholism. Mother died at age of 40 years; cause, tuberculosis. One sister died at age of 20 years; cause, tuberculosis. Two sisters and three brothers died during infancy; not definitely known, possibly tuberculosis. Two brothers and one sister living and well. The patient is the mother of four children, who were all born naturally. Two of whom are dead; cause, cerebro-spinal meningitis (probably of tubercular origin). The remaining two are in good health.

*Past History*—Positive to measles, chicken-pox, mumps and malaria; no complication. Negative to rheumatism, typhoid, pleurisy, pneumonia, jaundice or ascites.

*Habits*.—Patient's sleep is often disturbed by bad dreams, and has great difficulty in going to sleep again. Appetite has always been good; generally eats very slowly. Bowels, as a rule, are always regular, but have been constipated for past four weeks. Drinks regularly two and three cups of coffee for breakfast, and about the same amount of tea for supper. Does not use any intoxicating drinks or drugs.

*Menstrual History*.—Began when she was 14 years of age, and have been regular, occurring every month, and lasting about four or five days, accompanied by very little pain.

*Present Illness*.—About three years ago patient was treated in the Dispensary of University Hospital for gastralgia and nervousness. She improved under the treatment, and for about three years was in good health.

About 18 months ago patient underwent a very severe strain, nursing two of her children who were very sick. After the recovery of the one and the death of the other she found that she was very nervous, and that her stomach was giving her a great deal of distress which she had not noticed before. Medical treatment did not improve her, gradually getting worse until four weeks ago, when she became so weak that she could not do her housework any more; then she went to bed, which she has not left to the present time.

*Subjective Symptoms*.—Her attacks of indigestion, as she calls them, at first were several weeks apart when she first noticed them; later they became more frequent, until they occurred every third day. These attacks are characterized by a numbness and tingling sensation in lower and upper extremities; distention of the stomach; palpitation of the heart; a sense of weight in precordial region; eructations of gas and a small amount of liquid of a sour taste, and at the same time she would feel as if she were going to faint. They would come on her rather suddenly, and were promptly relieved by sodium bicarbonate and aromatic spirits of ammonia. The time of the attacks bear no relation to the amount or time of taking food, but seem more apt to occur after the ingestion of food difficult of digestion, like cabbage or beans. They are not accompanied by fainting or diarrhea. At present her appetite is very poor; even the sight of food causes no desire for it.

Her bowels have been constipated a greater portion of the time she has been in bed. Macroscopic examination of stools shows them to be of a brown color, well formed and rather solid; no mucus. Chemical test shows the absence of occult blood. No undigested food particles were noted upon microscopical examination.

*Blood Examination*.—Hemoglobin, 80 per cent.; leucocytes, 10,000; red cells, 4,480,000 per c. mm. Patient is somewhat emaciated, having lost about 20 pounds in the last five weeks.

#### PHYSICAL EXAMINATION.

*Mouth*.—Tongue protrudes in medium line, not tremulous; dorsum coated with a creamy fur. Teeth are in a poor state of preservation; mild

pyorrhea present; throat and tonsils not congested.

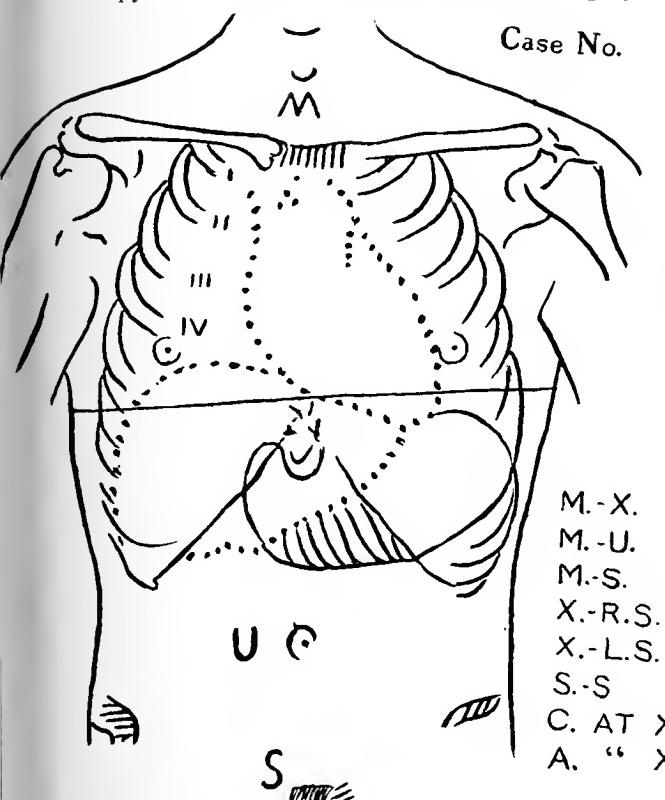
*Neck.*—Medium length; no enlarged glands or abnormal pulsations; no tracheal tug; no difficulty in swallowing.

*Chest.*—Negative to lung or cardiac troubles. Palpation showed floating tenth rib.

*Abdomen.*—Inspection shows a tendency to the scaphoid type. Marked abdominal pulsation noted. Gastric peristalsis in pyloric end of the stomach easily seen.

*Palpation.*—About three hours after a meal consisting of a glass of milk, one soft-boiled egg and a piece of toast the skin felt warm to the touch; no points of tenderness were noted over the abdomen. No succussion or splashing was noted. The left kidney was found to be freely movable; the right also. The spleen was not palpable; the liver did not extend below the costal margin.

*Percussion.*—Showed the lesser curvature to be just below the umbilicus, the greater curvature about four fingers below umbilicus, with most of the pyloric end to the left side and extending up-



Height.....Weight.....Age.....  
X Angle.....Pr. Weight.....

ward. Upon distending the stomach the outlines could be made out more plainly. The lesser curvature now being level with the umbilicus, and the greater curvature slightly lower than it was when not distended, as may be seen by accompanying diagram. Radiograph of stomach confirms these limits.

#### EXAMINATION OF TEST MEAL.

*Macroscopical Examination.*—Amount 30 c. c., of a clear straw color, slight sour odor, a few particles of undigested food, and small amount of mucus.

*Microscopical Examination.*—Few budding yeast cells, but no Oppler Boas bacilli or sarcinae.

*Chemical Examination of the Test Meal.*—The reaction was faintly acid. Free hydrochloric acid was absent, but lactic acid was present (Uffleman test). Total acidity was only three (3). Achylia gastrica. Proteolysis, 0.5 mm. Mett.

*Urine.*—Twenty-four hours' specimen, amount 1500 c. c. Acid reaction, light straw color and natural odor. Specific gravity, 1021; albumin and sugar negative. Microscopical examination of sediment showed the presence of a few leucocytes epithelial cells and an occasional hyaline cast and cylindroids, excess of indican.

*Diagnosis.*—Gastrophtosis, gastric neurosis and achylia gastrica.

*Etiology.*—The etiology of gastrophtosis is anything which causes a displacement of the abdominal viscera, as multiple pregnancies without proper support to the abdominal walls after parturition, acites, large uterine or ovarian tumors which likewise stretch the abdominal walls, and then after the removal from the abdomen leave the abdominal walls lax and pendulous, allowing the viscera to drag on their attachments. Pelvic inflammations and hernias have a tendency to cause a descent of the various organs by the tractions exerted on the viscera. But for most cases of enterophtosis the etiology is to be sought in some defect of development retraceable to embryonic life.

#### TREATMENT.

The prophylactic treatment in these cases would consist in supplying suitable support to the weakened and relapsed abdominal walls. Then, too, there are a certain number of cases which result from the loss of fat, as in the various chronic diseases, as tuberculosis, cachexia, chronic lues and carcinoma, protracted cases of malaria.

The treatment for this class of cases is to give

a diet which will restore the lost fat as soon as possible. Such a diet should be one rich in good butter, rich cream and abundance of such a diet as the gastric test meals and stool analysis demonstrate are fairly well digested.

The treatment for this patient should be one that would make an endeavor to increase her appetite; help her to increase in strength and flesh; cure her nervousness, and benefit the constipation. The first thing to do is to put her in good hygienic surroundings; (2) a bitter tonic for the appetite; (3) supply the deficiency of hydrochloric acid; (4) a good nutritious and easily digested diet; (5) a suitable bandage to supply support to the weakened abdominal muscles, at the same time instituting gymnastic exercises which will tone up the abdominal muscles; (6) occasionally bromides for the nervous irritability and insomnia.

The hygienic surroundings should include fresh air and sunlight; clean clothes and a comfortable bed, and a daily cold bath, as this will increase the tone of the skin and circulation; (2) for the bitter tonic, and the deficient hydrochloric acid, the following often does good:

R Acidii Hydrochlodicii Dil.

Fifty drops, largely diluted, after each meal.

R Strychniae Sulphatis, gr.  $\frac{1}{2}$ .

Elixir Gentinae, q. s., fl.  $\frac{5}{6}$  vi.

Sig. One tablespoonful before meals.

This also has a tendency to increase the motor functions or peristalsis of the stomach, as well as promote the secretion of gastric juice.

The diet should consist of milk, eggs and finely-minced meats, well-boiled rice, purée of potatoes, peas, beans, asparagus tips. As for the bandage, it should fit snugly and have a straight front, and made especially to fit this case. Most of the pressure should be on the iliac bones in front on the spine, well padded in front so as to support the stomach as much as possible. It should be put on with the patient's hips elevated as high as possible.

For the insomnia and nervousness the following should be tried:

R Potassii Bromidii, 5 iv.

Tinct. Valerian, fl.  $\frac{5}{6}$  vi.

Elixir Simplicis, q. s., fl.  $\frac{5}{6}$  vi.

M. Sig. Tablespoonful every two hours until sleep is induced.

A number of surgical writers recommend stitching the prolapsed stomach to the anterior

abdominal walls, so that there shall be no kinking of the esophagus. This has been done by Professor Hundley with very good temporary success. But in most cases where such cases were examined one year after this operation the stomach was again loose and in its old position.

#### DISCUSSION BETWEEN THE CLASS AND THE TEACHER.

The discussion in this case centered around the expediency or non-expediency of surgical treatment to replace the dislocated abdominal organs.

Literature was looked up and cited to show that prominent surgeons had receded from their former advice to operate for floating kidney or gastrop-tosis.

Professor Hemmeyer described three cases, two of whom had been shown before and after the operation, where the stomach fell back to its old position after it had been stitched to the dia-phragm and abdominal wall.

At a meeting of the present and former Super-intendents of the University Hospital of Baltimore, held May 3, 1910, the following resolutions on the death of Dr. Latane were adopted:

WHEREAS, we have learned of Dr. Samuel Peachy Latane's tragic and untimely death with horror and regret; and,

That we realize that the medical profession has lost a highly-esteemed member and the community in which he lived a useful citizen;

Therefore, Be It Resolved, That we extend our sincere sympathy to the members of his family in their great bereavement; and,

Be It Further Resolved, That a copy of these resolutions be forwarded to them.

C. W. Mitchell.

Henry M. Fitzhugh.

Frank Martin.

Arthur M. Shipley.

St. Clair Spruill.

Robt. P. Bay.

Dr. David M. R. Culbreth, formerly Professor of Materia Medica in the University of Maryland, medical department, and at present member of the Board of Regents and Professor of Materia Medica in the pharmaceutical department, is visiting in Richmond, Va.

Dr. H. E. Ames, class of 1874, surgeon United States Navy, has been detached from the Navy-Yard, Portsmouth, N. H., and ordered to the Asiatic station.

# THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, MD., MAY 15, 1910

## THE RETIRING EDITOR—DR. THOMAS A. ASHBY.

For five years Dr. Thomas A. Ashby has been the editor of THE HOSPITAL BULLETIN, but for various reasons has kept his name from the editorial pages. He has been the director in its various stages of existence. He has engineered it through the many journalistic pitfalls, and now, in the days of its prosperity, owing to press of other matters, is compelled to relinquish its editorship. Dr. Ashby has been indefatigable in the service of THE BULLETIN. Only those who have been associated with the upbuilding of a new medical publication can realize the amount of labor entailed in a successful launching. The University owes Dr. Ashby a debt of gratitude for the manner in which he has so successfully established THE HOSPITAL BULLETIN, and the present management thinks it no more than justice to the retiring editor that those who have had the pleasure of reading his charming editorials be made cognizant of the author's name.

## CHANGE OF MANAGEMENT.

With the present issue of THE HOSPITAL BULLETIN the business management is assumed by Dr. Nathan Winslow. The manager wishes to take this opportunity to thank the patrons of our journal—subscribers, contributors and advertisers—for past courtesies. It is superfluous to state that we hope that the same cordial relationship which has hitherto existed between us and our patrons shall be maintained. THE BULLETIN has been doing a great work for the University. It keeps the subscribers posted about the doings, success and

location of their friends. The most recent news of the happenings at the University are here quickly brought to the attention of its readers. It is a letter of the mother to her children. To make the journal a success the editors must rely on the co-operation of our alumni. Items of interest are especially solicited. This is decidedly the distinctive feature of THE HOSPITAL BULLETIN, but to the present time, owing to the bashfulness of our alumni, this field has not been developed to its fullest usefulness. Write to us; let us know where you are located and what you are doing. This information is of value to someone of your classmates. Besides, the University authorities are interested in your success.

We especially wish to call the attention of our subscribers to the impossibility of their receiving THE BULLETIN regularly if they fail to notify us of change of address. It is our endeavor to place THE BULLETIN regularly in their hands, and if perchance the mail miscarries a postal to that effect will promptly remedy the matter.

In the future address all communications, letters, papers for publication, etc., to Hospital Bulletin Co., 608 Professional Building, Baltimore, Md.

## THE LATE DR. SAMUEL P. LATANE.

We regret to announce to his many friends that Dr. Samuel Peachy Latane, a member of the class of 1897, formerly superintendent of the Hospital for the Women of Maryland and the University Hospital, one of the most prominent of our younger alumni, well-beloved by a host of friends, and for a number of years well known in medical circles in Baltimore, was instantly killed on Sunday evening, May 1, 1910, in an automobile accident in Winchester, Va., while on his way to visit a patient. Dr. Latane had left his machine at a garage, and was using a car borrowed from the owners of the garage, and was accompanied by two of the employes of the place. The machine refused to work properly while ascending a hill, and, after backing into a ditch, turned turtle, pinning Dr. Latane beneath the wreck. Death was instantaneous, his neck having been broken. Interment was at Mount Hebron Cemetery, near Winchester.

Dr. Latane was born in King and Queen county, Virginia, December 14, 1874, and was a member of the well-known Virginia family of that name.

His parents moved to Baltimore when he was five years old, and he received his education in this city. He graduated in medicine from the University of Maryland in 1897, receiving the Miltenberger prize. Afterwards he did graduate work at the University of Heidelberg and at Johns Hopkins. He was resident physician at the Hospital for the Women of Maryland, and afterwards superintendent of the University of Maryland Hospital. In 1901 he moved to Winchester, Va., and took up the practice of medicine there. In 1905 he married Miss Elizabeth Love, daughter of Dr. William S. Love of Winchester, and niece of Senator Faulkner.

Dr. Latane was a son of the late Bishop James A. Latane of the Reformed Episcopal Church, and in addition to his widow, is survived by his mother, who resides at 1412 Park avenue, and a large family of brothers and sisters. These are Dr. John H. Latane of Washington and Lee University, Lexington, Va.; Assistant State's Attorney James A. Latane, Misses Susan, Lucy, Edith and Lettice Latane of Baltimore; Mrs. Claggett B. Jones of Brington, Va.; Mrs. William D. Stevens of New York; and Mrs. Samuel McLanahan of Lawrenceville, N. J.

## ABSTRACTS

### AN UNUSUAL SURGICAL CASE UNDER LOCAL ANESTHESIA.

Dr. Guy Steele, class of 1897, of Cambridge, Md., writing in the *Maryland Medical Journal*, May, 1910, reports an operation for the radical cure of hernia and removal of appendix through left inguinal ring under local anesthesia, with recovery. He deems the peculiar anatomical findings and the rarity of the operation a sufficient explanation for the reporting of the case.

The reason for the employment of local anesthesia was a double broncho-pneumonia. The hernia was congenital, and was occurring and recurring until two days before he was called in, when it had become irreducible and remained so. He tried reduction by manipulation and change of posture; but, being unsuccessful, he advised the removal of the patient to a hospital and an immediate operation. The child was removed to the Cambridge Hospital, where Dr. Steele, assisted by Drs. E. P. Wolff and E. A. Jones, operated under local anesthesia. The usual incision for herniotomy was made, the sac freed and

opened. The bowel showed evidences of constriction, and its vessels were much congested, but not sufficiently so as not to warrant its return to the peritoneal cavity. Complicating the hernia was an undescended testicle and the presentation of the appendix in the inguinal canal. The appendix was removed, but as the condition of the patient did not warrant further operation the arrested testicle was not interfered with.

During the whole operation the only anesthetic used was 20 minimis of the one-tenth of 1 per cent. of novacain infiltrated into the superficial tissues. As far as could be determined, the whole procedure was absolutely without pain, except when artery forceps were tightly clamped on bleeding points somewhat outside of the line of infiltration and when the ligature was tightly drawn about the artery at the base of the appendix, a nerve evidently being included. Except for a brief and sharp cry at these times, the child was apparently the most unconcerned one present, rolling his eyes from side to side in evident wonder at his surroundings, but giving no further evidence of interest.

The patient was put to bed in good condition, little shocked, and went to sleep promptly. The bowels were moved well under small doses of calomel on the second day. Liquid nourishment was taken with avidity, and, indeed, during the whole course of the case the only trouble was to satisfy an almost insatiable appetite without overfeeding.

The lung conditions cleared up promptly, the wound healed perfectly and firmly, and the child made an uninterrupted and uneventful recovery, leaving the hospital on December 7 much improved in every way.

He trusts that it will not be thought that he deemed the results in this case and those in another, which he begged leave to mention, sufficient evidence upon which to base an absolute line of surgical procedure.

They point most strongly, however, to the fact that in desperate cases, where general anesthesia cannot be used, we can operate with safety, comfort and freedom from pain to our patients and freedom from anxiety to ourselves as to the condition of our patients under local anesthesia in weak and safe solution.

As another illustration the following case is mentioned:

On February 7, 1909, the late Dr. Percy Stansbury of Crapo, Md., sent to him from Lakesville,

Md., J. H. B., white, aged 60, with the following history:

A left inguinal hernia which had existed for years, giving no trouble, not preventing work, coming down occasionally and going back easily and painlessly.

The hernia had been down for two days, and had resisted all attempts at reduction, when Dr. Stansbury was sent for, who, being unable to reduce it, at once sent the man to him.

After a ride of 25 miles over wretched roads, on a bitterly cold day, the patient reached the hospital in a state of utter shock and collapse, almost speechless from cold; he was blue to his knees. The face was blue and pinched, respiration shallow, pulse quick and almost imperceptible.

During Dr. Steele's temporary absence from town his colleagues on the staff at once started vigorous measures to revive him, administering whiskey and cardiac stimulants, and surrounding him with hot-water bottles. Dr. Steele saw him that afternoon, and anxious as he was to operate quickly, not knowing the condition of the bowel, he found the patient too weak. As his condition was somewhat improved at night, he was carried to the operating-room. His condition was still so bad that Dr. Steele was afraid to use general anesthesia, so he infiltrated the skin and superficial tissues with a small amount of 2 per cent. solution of cocaine, determining to start the operation under this weak solution and to change to ether if he found that the patient could not stand the pain. To Dr. Steele's surprise and great satisfaction, except when artery forceps were tightly pinched on the tissues or ligatures tightly drawn, there was no pain and no shock.

The dissection was made, sac opened, bowel returned, sac sutured across and a large piece amputated, and stump sutured in ring. The wound was closed layer by layer with catgut and skin with interrupted silkworm-gut sutures. The result was a radical cure, with uneventful recovery.

Dr. Steele believes that in these cases had he used general anesthesia the patients would never have left the operating table alive. Had the practice of a few years ago been followed, when it was thought necessary to thoroughly saturate the tissues with a strong solution of cocaine, he fears the result would have been none the less prompt and sure. Here only 20 minims of a one-tenth of 1 per cent. solution of novacain was used in the

one case and 2 per cent. solution of cocaine in the other, and both operations were painless and shockless.

As points of especial interest in the first case he begs to call attention to:

1st. The exceeding rarity of an appendix in a left hernial sac.

2d. The rarity of the removal of an appendix through the left inguinal ring.

3d. The length of the appendix in a child of 20 months, the organ measuring five inches in length.

4th. The small amount of local anesthetic used, namely, 20 minims of a one-tenth of 1 per cent. solution of novacain.

5th. The freedom from pain and shock.

6th. The prompt and uninterrupted recovery from an operation of such severity when complicated with double pneumonia.

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#### CASE OF EPITHELIOMA OF ESOPHAGUS.

Walter Van Swearingen, M.D., class of 1904, of Washington, D. C., in the *Washington Medical Annals*, May, 1910, reports the following case of epithelioma of the esophagus:

T. W., male, age 69, entered hospital November 27, 1909. Family history and past history unimportant. He first noticed trouble about two weeks ago, when he regurgitated food and drink immediately after taking it; had considerable nausea, but no pain. Prior to this had had no symptoms at all except some loss of weight. Since then all food has been immediately regurgitated. Physical examination negative, except marked emaciation. Dr. W. F. M. Sowers attempted to pass a stomach tube, but met with resistance about 40 cm. from upper incisor teeth, and was unable to get the tube into the stomach. The diagnosis was stricture of esophagus at cardiac end of stomach, with consequent dilatation of esophagus. An X-ray was made after giving one ounce of bismuth subnitrate in a glass of milk. This picture bore out the diagnosis pretty well. His urine showed casts, but no albumen; leucocyte count, 9100.

*Autopsy Report.*—Pupils, nose, ears and teeth normal. No glandular enlargements and no surface markings except operative wound in epigastrium and several old scars on shins. Chest resonant throughout; abdomen tympanitic and boat-shaped; costal angle about 90 degrees. No excess of fluid in abdominal cavity; intestines moist and

glistening, and free from adhesions. Small quantity of bloody fluid in each pleural cavity. Pericardium normal. Heart small, flabby, anemic; valves normal, except aortic, which showed calcareous deposits on inner surface. Coronary arteries markedly sclerotic. Aorta somewhat dilated. Calcareous mediastinal gland. In esophagus, 34 cm. from mouth, opposite xiphoid appendix, was a mass completely blocking the canal for all solids, although fluids could possibly trickle through. The mass was more or less necrotic; a small rupture in it, probably done in removing it. Lungs showed hypostatic congestion and edema; several small healed tubercles in each. Liver apparently normal. Spleen small and firm; its surface covered with small white areas resembling miliary tubercles; on section showed interstitial splenitis. Kidneys smaller than normal; on section showed diffuse nephritis. Bladder and intestines normal.

On finding healed tubercles in the lungs and tubercles in the spleen, and a large calcareous mediastinal gland, it was thought that possibly the growth in the esophagus was tubercular, but microscopic sections proved it to be an epithelioma.

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## ITEMS

Ever since its organization in 1903 the General Alumni Association has had a weather-eye open as to how it can best further the interests of the University of Maryland. By the University of Maryland is not meant the medical department, the law department, the dental department, the pharmaceutical department, or the department of arts and sciences, each and every one taken individually, but the University as a whole. This Association has for its object the creation of a University of Maryland, a strong central organization which shall govern the several departments. Its members realize that to attain its goal a sentiment for a central organization has to be created, that the alumni of the various departments must be made to feel that they are children of a common mother, and not of a department, and that the authorities in control of the destinies of the University must be brought to see that strength will be added to their individual departments by a closer union with the other departments. Even with its few years of existence there can be noticed a notable increase

in the University spirit and idea. Men who had lost all interest in their alma mater are now taking a renewed interest in what is going on down on Lombard street. This in the future is sure to bear fruit.

The last effort of the General Alumni Association to create a better spirit between the teaching bodies, the alumni and the coming graduates has culminated in a decision to give a combined meeting and smoker to the graduating classes of the several departments. There will be "something doing." You will not regret coming. Show your interest by your presence. The executive committee has made arrangements whereby the meeting is to be held at the Faculty Building, 1211 Cathedral street, Baltimore, Md., May 30, 1910, at 8 P. M. Tickets can be obtained by sending a dollar to Dr. Charles E. Sadtler not later than May 23.

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Dr. Howard Elmer Ashbury, class of 1903, tendered the first annual smoker in the Howard Street Armory to Company A, Hospital Corps, Maryland National Guard. The room was decorated with the national colors and emblems of the medical department. The evening was spent in smoking and telling "war" experiences. Selections were given by the National Musical Club. Major Alexius McGlannan, chief surgeon, medical department, Maryland National Guard, made a short address on the coming encampment.

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Among the papers presented at the annual meeting of the Medical and Chirurgical Faculty of Maryland, held April 26, 27 and 28, the following were by alumni of the University of Maryland: "General Professional Responsibilities for Preventing Blindness and Preservation of Sight Growing Out of Recent Legislation," by Dr. Hiram Woods, class of 1882; "Typhoid Perforation," by Dr. Charles Bagley, Jr., class of 1904; "Anthropometric Studies of the Osseous Proportions of the Human Body, with a View to Obtaining a Mathematic Expression for Enteroptosis" and "The History and Techniques of Radiography as a means for Studying Conditions and Functions of the Digestive Tract," both by Dr. John C. Hemmeter, class of 1884; "Climatic, Soil and General Conditions in Maryland with Reference to Hookworm Disease," by Dr. Marshall Langton

Price, class of 1902; "Some Diagnostic Outfits for Communicable Disease," by Dr. William Royal Stokes, class of 1891; "The Proper Care of the Convict," by Dr. Theodore Cooke, Jr., class of 1891; "Some Abuses of Early Education," by Dr. William H. Pearce, class of 1891, and "The Diagnosis of Gastric and Duodenal Ulcer by the Roentgen Method," by Drs. Harry Adler, class of 1895, and Harry Elmer Ashbury, class of 1903.

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Dr. Craig Barrow, class of 1900, of Savannah, Ga., is a native of Athens, Ga., having been born there in 1876, the son of Pope and Sallie Craig Barrow. He is a graduate of the University of Georgia, class of 1896, and was president of his class at the University of Maryland, 1900. After graduation Dr. Barrow served for one year as resident physician at the University Hospital. He afterwards took a post-graduate course at the University of Breslau, Germany, and is now located in practice in Savannah, Ga. Dr. Barrow married Miss Elfrieda Revue of Savannah. He has a large private practice, and in addition is surgeon to the First Battalion, Georgia Heavy Artillery, and visiting physician to Savannah City Hospital.

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During the visit of inspection paid by the orthopedic surgeons to the Johns Hopkins Hospital, Dr. Howard E. Ashbury, class of 1903, gave an exhibition of cases; at the Crippled Children's Hospital a clinic was held by Drs. A. C. Harrison, class of 1887; Henry W. Kennard, class of 1899, and Prof. R. Tunstall Taylor.

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Dr. Franklin Pierce Hoover of Jacksonville, Fla., editor and proprietor of the *Florida Medical Journal*, is a graduate of the Medical School of the University of Maryland, class of 1884. He was born in Washington, D. C., July 6, 1862, the son of Jonah Davis and Angelica Pierson Hoover. He was educated in the public schools of Baltimore, then at the University, afterwards spending a year at Bayview Hospital. He practiced in Washington for five years, then spent 12 years at the Manhattan Eye, Ear and Throat Hospital, after which he took up his residence in Jacksonville, Fla. Dr. Hoover is married. He is connected with many medical societies, both in Florida and New York.

Dr. Fritz Lange, one of Europe's most noted orthopedic surgeons, demonstrated his methods of tendon transplantation before a well-attended clinic in the amphitheatre of the University Hospital May 2, 1910, at 2.45 P. M. The patient was a little girl from the Crippled Children's Hospital suffering with paralysis of the flexor muscles of the leg. The action of these muscles was substituted by transplantation of the peronei longus et brevis into the calcaneum attachment of the tendo Achillis according to his special method. In addition to the graduates and students, the University was honored by the attendance of a large delegation of the most prominent orthopedic surgeons of the country, now attending the Congress of American Physicians and Surgeons in Washington. Dr. Lange was introduced by Dr. R. Tunstall Taylor, Clinical Professor of Orthopedic Surgery in the University of Maryland. The visitors were welcomed by Dr. Randolph Winslow, Professor of Surgery in the University of Maryland, who greeted them with a few appropriate remarks. It is a noteworthy fact that within the past seven years three of the most prominent orthopedic surgeons of Europe have favored the University of Maryland with demonstrations of their technique, namely, Profs. Lorenz, Hoffa and Lange. The institution owes a debt of gratitude to these gentlemen for the favor of their presence and the inspirations to higher effort they have given, both to our alumni and students. Those who were not fortunate enough to witness Dr. Lange's demonstration missed a rare treat.

At the same session Dr. Compton Reily, class of 1897, presented to the visitors several cases of interest, and also demonstrated some orthopedic apparatus which he had recently perfected. Prof. R. Tunstall Taylor exhibited cases of internal derangement of the knee upon which he had operated with perfect functional results.

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A large number of local physicians attended the meeting of the Baltimore County Medical Society April 21 to hear Dr. William H. Welch, president of the American Medical Association, talk on the work accomplished by that organization in recent years. Among our alumni present were Drs. Marshall B. West, class of 1901; Lonis B. Henkel, class of 1903; Chas. W. McElfresh, class of 1889; Josiah Bowen, class of 1903; Henry A. Naylor, class of 1900; Henry L. P. Naylor, class of 1900; William S. Smith, class of 1883; N. H. D. Cox,

class of 1900; Henry L. P. Naylor, class of 1860; J. H. Jarrett, class of 1852; B. F. Bussey, class of 1884; J. A. Wright, class of 1891; Samuel T. Earle, Jr., class of 1870; L. Ernest Neale, class of 1881, and Nathan Winslow, class of 1901.

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The *Journal of the American Medical Association*, abstracts the article on "Tubercular Peritonitis," by Randolph Winslow, M.D., class of 1873, which was published in the April issue of the *Maryland Medical Journal*, as follows:

*Tuberculous Peritonitis.*—While some patients with tuberculous peritonitis undoubtedly recover without surgical intervention, Winslow believes that there is always the doubt as to the correctness of the diagnosis. Not all cases are appropriate for surgical operation, but great benefit and permanent cure follows laparotomy in at least 50 per cent. of suitable cases. The cases in which there is free fluid in the peritoneal sac, with little or no evidence of disease elsewhere, are best treated by surgical methods; the adhesive forms sometimes are cured by laparotomy, but in a much smaller proportion of cases. After the patient has been subjected to surgical treatment, all other measures of a hygienic, climatic and medicinal character that have been found useful in pulmonary tuberculosis should be employed.

The article in the same issue by Dr. Herbert Harlan, class of 1879, on "State Boards and High Entrance Requirements" was abstracted in the *Journal of the American Medical Association* of April 16, 1910.

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An oil painting of Dr. Moreau Forrest of Washington, D. C., a graduate of the University of Maryland, class of 1826, was presented to the University by Miss Mary Dashiell Robinson, the step-daughter of Dr. Forrest. The painting has been hung in Davidge Hall.

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Dr. Oliver Parker Penning, class of 1897, of 1711 St. Paul street, Baltimore, is a patient at the University Hospital. Dr. Penning was, after graduating, an interne in the University for several years. Since engaging in practice, Dr. Penning has become one of the most prominent of our younger set. He was born at Darlington, Harford county, Maryland, January 26, 1869. His elementary education was obtained at the Havre de Grace High School, whence he graduated in

1886. His medical education was obtained at the University of Maryland, whence he graduated with the class of 1897. Since graduating he has been connected with the surgical department of his alma mater. THE BULLETIN sincerely hopes that in the very near future it will be able to report to Dr. Penning's friends that he has sufficiently regained his erstwhile good health and has resumed his professional duties.

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Dr. William Tarun, class of 1900, of Baltimore, has resigned as assistant surgeon to the Presbyterian Eye, Ear and Throat Hospital of Baltimore, and in the future will devote his entire attention to the eye and ear department of the University of Maryland. Immediately after graduating Dr. Tarun became associated with the eye department of the Presbyterian Hospital, where he has done excellent work for the past 10 years, but, owing to the stress of professional duties, decided to devote his spare time to the eye and ear department of the University. We are glad to announce that Dr. Tarun has made good in his specialty, and is one of our most promising young men.

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Dr. Frank S. Lynn, class of 1907, has returned from Europe, where he pursued a course of study in macroscopical pathology, under Prof. Hans Chiari, in Strasburg University, Strasburg, Germany. While abroad he spent considerable time at the clinics of Vienna, Berlin and London.

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Dr. James Bordley, class of 1896, has returned to his home in Mt. Washington after a visit to Old Point Comfort, Va.

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Amongst the recent visitors to the University Hospital was Dr. William F. Sappington, class of 1901, of Webster's Mills, Pa. Dr. Sappington was in the best of health, and reports that he is doing nicely in his chosen field. "Old Sap" never fails to drop in on his friends when in town, and the writer may say, on his part, that he is a welcome visitor.

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Dr. Francis W. Janney, class of 1905, of Baltimore, has severed his connection as assistant surgeon to the Presbyterian Eye, Ear, Nose and Throat Hospital, and has accepted a similar position with the eye department of the Baltimore

Eye, Ear, Nose and Throat Hospital. Dr. and Mrs. Janney are also open to congratulations upon the birth of a baby girl.

Dr. William F. Hala, class of 1905, of New York city, is one of the associate editors of the *Medical Review of Reviews*. He is connected with the neurological department.

Dr. Henry O. Reik, class of 1891, is registered with Mrs. and Miss Reik at the Chalfonte, Atlantic City.

Dr. Summerfield B. Bond, class of 1883, and Mrs. Bond will spend the summer at North Hatley, as has been their custom for several years.

Dr. Thomas C. Baldwin of Whitehall, Md., received a fracture of the arm by being thrown to the ground by a horse. He underwent treatment at the University Hospital.

Dr. Louis McLane Tiffany, class of 1868, and Mrs. Tiffany have opened Mount Custis, their country home near Onancock, Va., for the spring season.

Dr. B. H. Dorsey, class of 1901, United States Navy, has been detached from the "Pennsylvania" and ordered to continue other duties.

Dr. Charles W. Mitchell, class of 1881, Professor of Medicine and Diseases of Children in the University of Maryland, will spend the summer in Europe, where he will pursue special courses in Vienna and Berlin.

Dr. Robert H. McGinnis, class of 1897, has been connected with the United States Marine Hospital Service at Jacksonville, Fla., since 1899. He is a North Carolinian, having been born in Mecklenburg county November 15, 1869, son of E. Decatur and Laura (McDowell) McGinnis, and is of Scotch-Irish blood. He attended the public schools in Charlotte, N. C., graduating from the Macon High School, afterwards entering the University of Maryland. He served in

the University Hospital one year as interne and one year as resident physician, entering practice in Jacksonville June 1, 1898. Dr. McGinnis was president of the Duval County Medical Society in 1904-05, and is a member of the Florida and American Medical associations.

Dr. Lawrence Sterling Alexander, class of 1868, of St. Augustine, Fla., is a native of Centerville, Va.; born there September 15, 1842, the son of Dr. Robert and Ann Clark Alexander of South Carolina. He studied in the public schools of Centerville, spent one year at the University of Virginia, Medical Department, and then matriculated at the University of Maryland, graduating in 1868. He has practiced successively at Manassas, Yorkville and St. Augustine. He is now county physician of St. John's county, Florida, and consulting physician to the Flagler Hospital of St. Augustine. He married Miss Mary I. Addicks of Yorkville, S. C.

Dr. Bartolo Pedro Oliveros, class of 1883, Savannah, Ga., was born in Jacksonville, Fla., August 3, 1860, the son of John B. Oliveros and Virginia Phillips Oliveros. He is of Spanish descent on the paternal side and English on the maternal. He received his early education in the public schools of Savannah, Ga., and his classic at Spring Hill College, near Mobile, Ala. He entered the University of Maryland Medical School in 1880, and, after his graduation in 1883, returned to Savannah, where he engaged in general practice, where he has been very successful. He is at present a member of the medical staff of Savannah City Hospital, and is a former president of the Georgia Medical Society. Dr. Oliveros married Miss Caroline Julia Izlar, daughter of Judge James F. Izlar of South Carolina.

Dr. John C. Hemmeter, class of 1884, Professor of Physiology in his alma mater, recently celebrated his 44th birthday very quietly at his home in Baltimore. Many floral tokens were tendered him, and a number of his friends called to offer their congratulations.

The quarterly meeting of the Maryland Psychiatric Society was held April 21 at Athol, the home of Dr. Alfred Gundry, near Catonsville, Dr. Gundry presiding. Dr. J. Clement Clark, class of 1880, told of the plans for improvements and en-

largements at Springfield. Among those who attended the meeting were Drs. Howard W. Jones, class of 1903; Newdigate M. Owensby, class of 1904; Henry O. Reik, class of 1891, and William F. Schwartz, class of 1907.

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The University of Maryland Training School for Nurses held its commencement exercises on Friday evening, May 6, at Lehmann's Hall. Dr. Robert S. Coupland, rector of the P. E. Church of the Ascension of Baltimore, opened with prayer. The diplomas were conferred by R. Dorsey Coale, Ph.D., dean of the Medical Faculty, and the address to the graduates was made by Dr. Arthur M. Shipley, class of 1902, Professor of Therapeutics and Surgical Pathology in the University of Maryland. The graduates were:

Ellen Coleman Israel, Maryland.  
Emelia Augusta Strohm, Maryland.  
Gertrude Anne Garrison, Virginia.  
Adele Davis Barrett, Georgia.  
Margaret Means Taylor, West Virginia.  
Florence Dandlet King, Maryland.  
Mary Morgan Kimmel, Maryland.  
Sarah Ambrose Lee, Virginia.  
Sarah Lillian Long, Maryland.  
Lulu Conway Price, Maryland.  
Cora Nellie Burton, Maryland.  
Virginia Opie McKay, Maryland.  
Marie Belle Murchison, North Carolina.  
Martha Venable Edmunds, Virginia.  
Anne Melisse Drye, North Carolina.  
Pauline Brock Pleasants, Maryland.  
Mary Constance Wiggin, New York.  
Lucy Briscoe Barber, Virginia.  
Agnes Kirk Holland, Maryland.  
Frances May Meredith, Maryland.

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We note by the thirty-second annual report of the Presbyterian Eye, Ear and Throat Charity Hospital of Baltimore that our alumni hold the following positions: Members of the Board of Governors—Drs. George A. Fleming, class of 1884; Horace M. Simmons, class of 1881, and Hiram Woods, class of 1882. Executive Surgeon—Dr. Herbert Harlan, class of 1879. Consultants—Drs. J. Frank Crouch, class of 1890; Charles Wellman Mitchell, class of 1881; Henry Briscoe Thomas, class of 1888; Henry M. Thomas, class of 1885, and Gordon Wilson, Associate Professor of Practice of Medicine. Surgeons comprising the

Medical Board—Drs. Herbert Harlan, class of 1879; Hiram Woods, class of 1882; Richard H. Johnston, class of 1894, and Leo John Goldbach, class of 1905. Assistant Surgeons—Drs. Charles Frederick Nolen, class of 1890; George A. Fleming, class of 1884, and Edward Engler Gibbons, class of 1895. Clinical Assistant—Dr. J. Claggett Robertson, class of 1900. Resident Physician—Dr. Slocum Rupert Edwards, class of 1908; and Pathologist, Dr. Leo John Goldbach, class of 1905.

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The fifth annual dinner of the Haverford Society of Maryland was held Saturday, April 7, and was largely attended. The University of Maryland was represented by Drs. Henry M. Thomas, class of 1885; Randolph Winslow, class of 1873, and FitzRandolph Winslow, class of 1906.

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Dr. Gordon Wilson, Associate Professor of Practice of Medicine in the University of Maryland, gave a talk on tuberculosis before a number of citizens of Frederick at a meeting held at the Woman's College under the auspices of the Frederick County Branch for the Prevention and Relief of Tuberculosis.

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Dr. Francis W. Janney, class of 1905, has removed from Catonsville to 2416 St. Paul street, Baltimore, Md.

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Amongst our alumni residing in Baltimore are:  
Doctors—

John Dwinelle Fiske, 51 South Gay street.  
John G. Jay, 869 Park avenue.  
Richard Hall Johnston, 919 North Charles street.  
Howard W. Jones, 1296 Frederick avenue.  
James Burch Joyce, 1800 West North avenue.  
Howard Kahn, 2027 West Pratt street.  
Nathaniel Garland Kierle, 1419 West Lexington street.  
Charles J. Keller, 222 West Monument street.  
Vernon F. Kelly, 405 Falls road.  
Henry Waters Kennard, The Winona.  
George S. M. Kieffer, 1414 Mt. Royal avenue.  
John Theodore King, 1425 Eutaw place.  
Francis John Kirby, 110 East North avenue.

Louis William Knight, 414 North Greene street.  
 Harry Edward Knipp, 1002 West Lanvale street.

John J. R. Krozer, 662 West Lexington street.  
 Charles Willis Larned, 1327 Park avenue.

Alvin B. Lennan, 742 North Patterson Park avenue.

Howard Davis Lewis, 38 West 25th street.  
 William Milton Davis, 1220 Linden avenue.  
 George Carroll Lockard, 1631 West Lafayette avenue.

William S. Love, 836 West North avenue.  
 James Madison Lynch, N. W. cor. Valley and Preston streets.

Harry Downman McCarty, 613 Park avenue.  
 Alexander Douglas McConachie, 805 North Charles street.

Thomas Pugh McCormick, 1421 Eutaw street.  
 Charles Corfield McDowell, 1521 W. Fayette street.

Charles W. McElfresh, 854 West Lombard street.

John Noland Mackenzie, 605 North Charles street.

George W. Mahle, 1903 West Baltimore street.  
 Howard J. Maldeis, 437 East 25th street.

Tilghman B. Marden, 2403 Maryland avenue.  
 Frank Martin, 1000 Cathedral street.

Samuel K. Merrick, 824 Park avenue.  
 William Irving Messick, 1606 Madison avenue.  
 Irving Miller, 108 East North avenue.

Charles Wellman Mitchell, 1002 Cathedral street.

George Washington Mitchell, 913 North Broadway.

Robert L. Mitchell, 2112 Maryland avenue.  
 Wilbur Phelps Morgan, 315 West Monument street.

Leonard Ernest Neale, 108 East Read street.  
 Charles F. Nolen, 114 West Franklin street.  
 Richard Baxter Norment, 3543 Chestnut avenue.

Vernon Lee Norwood, 939 West Fayette street.  
 Thomas J. O'Donnell, 405 Warren avenue.  
 Charles O'Donovan, 5 East Read street.

Henry Charles Ohle, 1203 West Fayette street.  
 John T. O'Mara, 1019 Edmondson avenue.  
 Martin A. O'Neill, 108 North Fulton avenue.

Fred'k Strattner Orem, 2827 North Calvert street.

Newdigate M. Owensby, 1820 North Charles street.

Edward R. Owings, 1733 Linden avenue.  
 Isham R. Page, 1206 Linden avenue.  
 William Herbert Pearce, 2105 North Charles street.

Frank White Pearson, 1511 Bolton street.  
 Oliver Parker Penning, 1711 St. Paul street.  
 John J. Pennington, The Marlborough.  
 Edgar Shirley Perkins, The Rochambeau.  
 Armenius Cleveland Pole, 2038 Madison avenue.

Robert Lee Randolph, 816 Park avenue.  
 J. Dawson Reeder, 639 North Fulton avenue.  
 John H. Rehberger, 1709 Aliceanna street.  
 E. Miller Reid, 904 North Fremont street.  
 A. J. Neilson Reik, 506 Cathedral street.  
 Henry Ottrage Reik, 506 Cathedral street.  
 William Whittall Requardt, 829 North Eutaw street.

Compton Riely, 4 West 20th street.  
 Charles H. Riley, 1113 Madison avenue.  
 William Miller Roberts, 1116 St. Paul street.  
 Harry N. Robinson, 2004 Wilkins avenue.  
 John Henry Robinson, 726 East Preston street.  
 Joshua Rosett, 1503 East Baltimore street.  
 Anton George Rytina, 330 North Charles street.  
 Charles E. Sadtler, 1415 Linden avenue.  
 William Christian Sandrock, 1242 North Broadway.

C. P. Otto Schaefer, 951 Madison avenue.  
 William F. Schwartz, 1200 North Caroline street.

Joseph Albert Seligman, 1920 Linden avenue.  
 W. B. A. Sellman, 5 East Biddle street.  
 Joseph M. Shemwell, 2226 Madison avenue.  
 Arthur Marriott Shipley, 1530 Linden avenue.  
 Horace M. Simmons, 1706 Park place.  
 Charles E. Simon, 1302 Madison avenue.  
 Albert G. Singewald, 1506 East North avenue.  
 Edward M. Singewald, 5 North Washington street.

Charles Urban Smith, 330 North Charles street.  
 Frank R. Smith, 1126 Cathedral street.  
 Henry Lee Smith, 2701 North Calvert street.  
 J. Holmes Smith, Jr., 2205 St. Paul street.  
 Joseph T. Smith, The Cecil.  
 Marshall G. Smith, 1628 West Lexington street.  
 Nathan Ryno Smith, 211 W. Madison street.  
 William Henry Smith, 3429 Chestnut street.  
 William S. Smith, 330 North Charles street.  
 Irving Spear, 1810 Madison avenue.  
 St. Clair Spruill, 1002 Cathedral street.

William Royal Stokes, 1639 North Calvert street.

William P. Stubbs, 647 North Calhoun street.  
Thomas J. Talbott, The Marlborough.  
George Lane Taneyhill, 1103 Madison avenue.  
William Tarun, 613 Park avenue.  
Samuel Theobald, 970 North Howard street.  
Henry B. Thomas, 1007 Cathedral street.  
Henry M. Thomas, 1228 Madison avenue.  
Louis McLane Tiffany, 831 Park avenue.

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The Nurses' Alumnæ Association of the University of Maryland entertained the graduating class of this year at the University Hospital on May 7. This is a new custom which the Association intends to maintain permanently. It is a move in the right direction, and we are glad to know that the past graduates of the University Training School are taking such an interest in the present classes. It proves that the forces are gradually working toward closer unity of the different elements of the University. Besides the members of the graduating class, many of the former graduates showed their interest by their attendance, those present numbering 45 in all. The committee of arrangements consisted of Mrs. Nathan Winslow, chairman, and Misses Hoftrawser, Nellie Serrel, Louise Pue and Katherine Dukes.

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Dr. John Smallbrook Howkins, class of 1897, of Savannah, Ga., well known to the members of that class as the artist from whose pen came many of the illustrations of the '97 yearbook, is located in Savannah, where he has been more than successful in his chosen field of endeavor. He is a native of Newark, N. J., and is the son of William J. and Maria Smallbrook Howkins. He matriculated at the University of Maryland in 1894, graduating in 1897. Dr. Howkins married Miss Elsie Heyward of Savannah. He was one of the founders in 1904 of the *Georgia Practician*, of which he is the present business manager.

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Dr. Marion Norwood King of Texarkana, Ark., holds two degrees from the University of Maryland—that of D.D.S. having been won in 1897, and the one of M.D. the year following, 1898. Dr. King won the University gold medal of 1897 and also carried the prize for surgery in 1898. He served for one year as assistant resident sur-

geon in the University Hospital, afterwards locating at Norfolk, Va., where he practiced for three years. He then took a graduate course in Berlin, and returned to America, settling in Texarkana, Ark., where he has risen to a position of prominence and respect. Dr. King was born in Warrington, N. C., October 15, 1874, the son of Dr. Joel G. King and Elizabeth Massenberg King. His early education was secured at Warrington Male Academy.

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Dr. H. Burton Stevenson, class of 1892, was shot and seriously wounded on May 16 at his home at Sherwood, Md., by his brother, Allen Stevenson, while the latter was temporarily deranged. The bullet entered the left side of the face and lodged in the right shoulder. Dr. William F. Smith, also of Sherwood, examined the wound and accompanied Dr. Stevenson to the University Hospital, where he is now resting comfortably.

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Miss Mary Wilson, formerly assistant superintendent of the University Hospital and now engaged at the Hospital for the Women of Maryland, recently sustained partial dislocation of her sacro-iliac articulation as the result of lifting a patient. We are glad to announce to her many friends that she is steadily improving and expects in the course of a month to be able to resume her duties.

---

Dr. Marshall G. Smith, class of 1887, has returned from a visit to the Traymore, Atlantic City, N. J.

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Apropos the present appearance of Halley's comet, the following poem by Dr. Thomas E. Bond, Jr., class of 1834, which was published in the *New Eclectic Magazine*, issue of April, 1870, and recently republished in the *Baltimore Sun*, may be of interest to our readers. The poem was probably inspired by the comet of 1861, which, it is said, returns but once in four centuries, this fact lending impressiveness to the latter verses of the poem. Dr. Bond was the son of Dr. Thomas E. Bond, and his son, Dr. Allen Kerr Bond, class of 1882, also followed him in his chosen profession. Dr. Thomas E. Bond, Jr., practiced for many years successfully in Harford county, but feeling an inclination toward religious endeavor, followed the dual rôle of min-

ister and physician, whose zeal in Christian work won for him the title of "Defender of the Church." Dr. Bond also won renown as a writer on religious topics, being editor of the *Christian Advocate and Journal* for 12 years:

## THE COMET.

Is it an arrow from th' Almighty hand  
Feathered with wavy flame? Has it been  
hurled

Through spaces measureless, a fiery brand  
On vengeful mission 'gainst some rebel world?

Is it a spirit speeding through the night  
That on our wondering sky his radiance flings?  
A strong-plumed messenger, who throws the light  
In mighty pulses from his quivering wings?

Is it a molten mist, wrapped on the rod  
Of molding Deity; for ages whirled  
In dizzy circles round the throne of God  
Till shaped, to blaze, a sun—or roll, a world?

\* \* \* \* \*

Thou formless haze from plastic ether rent!  
Thou unknown glory of the Maker's plan!  
Say! on what Godlike errand art thou bent?  
Thou thought of God! Thou mystery to man!

Thou flashing wonder of the firmament!  
What'er thou art, or hast been, or shalt be,  
I ask in vain; but hast thou not been sent  
Down thy long path of stars with words to me?

Oh! I do hear the hymning in the night  
Among the silent watchers! As I gaze  
Upon thy lustrous train, thy streaming light  
Shadows God's glory—palpitates His praise!

For ages thou hast swept through starry ways  
And found new glories in the lengthening skies,  
Where setting suns stretch forth their quivering  
rays

And touch the kindly beams of suns that rise.

Through boundless spaces thronged with glowing  
spheres

For ages more I trace thine arrowy flight,  
'Mid thickening splendors, till thy bound appears,  
Unpassed by matter, woven, though, of light.

And now, what worlds appear! What glories  
shine!

Where spirits glance before the dazzled eye;  
Cherub and seraph! forms almost divine!  
And God's own glory flashes on the sky!

Soon thou shalt sink away into the deep  
Of stars. The fathomless abyss shall fold  
Around thee, till upon thine orbit's sweep  
Thy years of absence shall again be told.

Then in our sky once more thy silvery train  
Shall glide in beauty and compel the gaze  
Of human eyes as now; but not again  
Shall these behold the splendor of thy rays.

Thy light may darken on some mossy stone  
Browned by corroding years, where I shall  
sleep  
In hope of joyous waking; but not one  
Of all thy watchers will come there to weep.

\* \* \* \* \*

Alone with God! with Him who burnished thee  
And set thee in the Heavens, and bid thee wave  
Thy yearly banner o'er infinity!  
Alone with God! and resting in the grave!

Alone, but not alone! Who watches all,  
And brings thee, joyous, from the azure deep,  
Shall watch the sunken tomb; yes! He will call  
His guarded servant from that peaceful sleep.

Asleep, but not in spirit! if, as thou,  
I hold my onward way, though tremblingly,  
Long ere earth sees thee, as thou shonest now,  
God shall have given a brighter robe to me!

THOMAS E. BOND.

—*The New Eclectic Magazine, April, 1870.*

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Dr. Charles O'Donovan, class of 1881, is a member of the executive committee of the Maryland Society of Social Hygiene.

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Dr. William F. Schwartz, class of 1907, has been appointed physician to the State Penitentiary, vice Dr. Theodore Cooke, Jr., class of 1891.

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Dr. Pierre George Dausch, class of 1868, is a native of Baltimore, and was born April 30, 1850, the son of Anthony Dausch. He graduated from Loyola College, receiving the degrees of A.B. and A. M., afterwards matriculating at the University of Maryland, whence he graduated in 1868. Dr. Dausch has practiced medicine in Baltimore more than 40 years. He became a part of the teaching force of the College of Physicians and Surgeons

in 1870, and was editor of *The Physician and Surgeon* during the years 1872-3. He has been a member of the Medical and Chirurgical Faculty since 1874. He resides at 121 Jackson Square.

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Dr. J. Fred Adams, class of 1894, entertained the house men of the University of Maryland at his home, 1314 North Charles street, May 16. About 50 were guests, and a thoroughly enjoyable evening was spent. Besides the students, Drs. Robertson, Craighill, McElfresh, W. H. Smith, Hooper, Bay and Nathan Winslow were present.

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Dr. Elmer C. Kefauver, class of 1891, of Thurmont, Frederick county, Maryland, who has recently been elected Town Commissioner for Thurmont, is at the head of an association, just organized, to boom that town.

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Dr. W. J. Riddick, class of 1905, assistant surgeon, United States Navy, has been detached from the "South Carolina" and ordered to the "Solace."

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We are sorry to announce that Dr. Thomas E. Latimer, class of 1907, was defeated in his campaign for the Mayoralty of Hyattsville by W. C. Magruder by the small majority of 105 votes.

## MARRIAGES

Dr. David Franklin, gold medalist of the class of 1908, was married on April 3, 1910, to Miss Mary Bearman of Baltimore.

## DEATHS

Rev. Dr. Henry Ustiek Onderdonk, class of 1873, died at his home in Buffalo, Wyo., May 10, 1910. Dr. Onderdonk was born in the Green Spring Valley in 1849, a son of the late Henry Onderdonk, formerly head master of St. James' School. He taught at the school for 25 years, and after his father's death became head master of a school at Laramie, Wyo. Later he took charge of a mission and was ordained a minister. At the time of his death he was pastor of the Protestant Episcopal Church in Buffalo, Wyo.

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Dr. Charles S. Kerr, class of 1868, of Kerr, N. C., died at his home March 6, 1910. He was one of the most prominent men in his section and enjoyed a large practice. He was president of

the Sampson County (N. C.) Medical Society in 1909.

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Mrs. Ellen Mezick Ridout, 50 years of age, wife of Dr. Zachariah Duvall Ridout, class of 1869, and a prominent physician of St. Margaret's, Anne Arundel county, died at her home on April 13, 1910, of pneumonia. She is survived by her husband and two daughters.

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Dr. William David Jones, class of 1902, of 2419 Elliott street, Baltimore, Md., died Sunday, April 17, 1910, from a complication of diseases. Dr. Jones was born in 1878. He received his primary education in the public schools of Baltimore, afterwards attending the medical school of the University of Maryland, from which he graduated in 1902. He is survived by his mother, Mrs. Evan Jones, and two sisters—Mrs. Nellie Mumford and Mrs. Miriam Vogel. Interment was in Mt. Carmel Cemetery.

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Dr. James Shadwick Spiller, class of 1870, of King William, Va., died at his home March 12, 1910, aged 61 years.

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Dr. Benjamin R. Davidson, class of 1867, of Davidsonville, Anne Arundel county, Maryland, died at the Hebrew Hospital, Baltimore, Sunday, May 1, 1910, of paralysis, aged 64 years. Dr. Davidson was, as the time of his death, Register of Wills of Anne Arundel county. He was also a member of the Democratic State Central Committee. Dr. Davidson is survived by his widow by a second marriage, who was Miss Nancy Iglehart, daughter of the late James H. Iglehart; a daughter, Miss Alice Davidson, and a son, Mr. Thomas Davidson.

Dr. Davidson practiced medicine in his home county. He was a member of the family from which his home village received its name, and which family was, before the Civil War, one of the largest owners of land and slaves in the county. Dr. Davidson is the last of his generation in this section, a brother, Ernest Davidson, having been killed by lightning about a year ago.

Dr. Davidson was active in Democratic politics. He had been Treasurer of the county and Register of Wills. He was known as a man of high character and professional attainments. He was particularly helpful to the poor of the community, giving his services free to many who were unable to pay.

# THE HOSPITAL BULLETIN

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No. 4

## ADDRESS TO THE GRADUATES OF UNIVERSITY OF MARYLAND, 1910.\*

By HENRY B. F. MACFARLAND,  
*Late Commissioner of the District of Columbia*

Speaking of the comet, Dr. St. Clair McKelway of Brooklyn, the editor of the Brooklyn *Eagle*, told me that he saw the comet of 1858; before my time and yours. Probably the provost remembers it. The university certainly remembers it, for I understand the university antedates the Dartmouth college decision and holds to its rights under that decision. He was the son of a country doctor, the best kind of doctor you may say, down in Missouri. When the negroes told him that when that comet struck the earth, as it soon would, the day of judgment would be here and the end of the world would come, he believed it. Late one afternoon his father sent him with a prescription for a patient a mile or two away, and as he came back darkness came on, the stars came out, the comet blazed larger than ever, and looked as if it was about to strike. He started to run down the dark lane through the wood, a short cut to his father's place. Suddenly in that lane rose up a tall form with a long white beard and a deep voice and said: "St. Clair, is that you?" Whereupon he replied: "No, Lord; no, Lord, it's my brother John!" Now, today I am brother John. I am not the conventional commencement orator.

I shall not eulogize the State of Maryland. It needs no eulogy from me. Nor shall I eulogize the city of Baltimore. No one could add to its praise. I shall not eulogize the University of Maryland. I am very glad to say that I think that also is unnecessary. For a century or more eulogy after eulogy has been pronounced at these exercises upon the State of Maryland, the city of Baltimore, and the University of Maryland and the

graduates who are about to go out, until really there is nothing left to be said. I shall not even eulogize these graduates. That is quite unnecessary. These charming ladies, some of them so high above us in the galleries as to remind us once more that we are created a little lower than the angels, testify to that. And if you could look into the faces of the handsome and intelligent men before me, I am very sure you would agree with me that it goes without saying that this is the best lot of graduates ever turned out by the University of Maryland.

These "old grads" back of me may not agree with me. I cannot see the expressions on their faces. Enough for me that I can see the pleased expressions upon the faces of these graduates before me.

Neither shall I give you any advice of a personal character. I do not give advice, I sell it. And I find that nobody wants advice unless they have to pay for it. You gentlemen who are going out to be lawyers, or at least members of the bar, and you gentlemen who are going to be physicians or surgeons, or at least members of the medical profession (broadly this is a sort of advice), you must learn not to give advice. You must give service, but when you offer advice it is not taken. And when you are asked for it be sure to charge for it, and charge well. I am against low fees. I think you should charge, in the words of the great Vanderbilt, "all that the traffic will bear." "Rob the rich" (at least that is what they will say about you), "in order that you may feed the poor." If I were going to offer advice as to your personal affairs, I think I should say simply this, that you have learned through this ancient university to be more than lawyers or doctors or pharmacists or dentists or scholars of the arts and sciences, that, above all, you are to be men.

This university has sought to give you a spirit more precious than any knowledge. That spirit, if you will let it, will make you the man that you should be—humane, courteous, true, pure, honor-

\*Address delivered at the one hundred and third annual commencement, Academy of Music, June 1, 1910.

able. That means success of the only kind that is worth while. The only kind that will last.

I am here, as I said, not to give you advice, but to make an appeal, in the name of the state, that you may be true citizens; that you may do your full civic duty, in the highest sense of those words, to your city and your state and your country. Now, this is no platitude. This is a thing that every one of us needs to remind himself of every day of his life, because the great temptation is to become so absorbed in the pursuit of riches, or simply in the profession, in the occupation, in the thing we are doing, so that we come to think there is nothing else in the world except our immediate circle of interest. But every one of us owes all that he has to the state, speaking of the whole community under that term. Every one of us, therefore, is a trustee of all that he has for the state, for the whole community, and through it for the world at large. It is not enough that you should pay your taxes; that you should vote when you have the opportunity. All citizens are divided into three classes—tax dodgers, taxpayers and those who do their whole duty, which is more than taxpaying and vote casting. You men who are going to be lawyers help to lift the reproach so often justly placed upon members of our profession, that we are not public-spirited; that we do not lead in civic reform or national thought. There are honorable exceptions, but we do not even through our bar association purge the bar of unworthy members, and our ethics, of which we boast, become commercial, so that our profession may degenerate into a commercial business. After you have done that, after you have done your whole duty as a lawyer, still there remains much to be done. It is to the honor of lawyers and doctors, and of all the others represented by your class, that they have done so much in the past for the state. There are men on this platform, like the provost, like other officers of this university, who have illustrated all the shining qualities of the true citizen, but there are hundreds and thousands of others who have had all that the state could give, who have lived absolutely selfish lives and disregarded the plain call of duty. The college man must remember that he has been privileged over the other men of his day, and, noblesse oblige, must return at least as much as he has received. "To whom much hath been given, from him justly shall much be expected," and he must pay or be dishonored. What do we say of the trustee who embezzles the trust fund? What should

we say of the college graduate who has taken the life-blood of his university, with all the knowledge that the ages have handed down, giving him an opportunity at the opening of this century such as no man has ever had before, who then proceeds to embezzle all that for his personal profit and his personal pleasure? It is to the honor, as I have said, of the professions represented here that the charge cannot be brought justly against all their members. Notable things have been done and are being done. Notable things have been achieved. The country and world are far better because of the unselfish devotion to duty of many men, and notably the graduates of our colleges. I was reading today the statute of 1814, forbidding members of Congress making contracts with the United States Government, and the official report that at that time members of Congress entered into contracts for their personal advantage. At one time a senator of the United States said that, counting those whom he had in Federal service and in the departments in Washington, he had 490 persons in the service of the United States placed there by himself. We have advanced a long way since then. We have advanced a long way in commercial honor, in commercial ethics, so that some men of the last century have come down into this century like polar bears on an ice floe which has melted from under them in the gulf stream of new public opinion prompted by a new public conscience. There has been a great change, and college men have helped mightily to bring it about. Wherever you find a committee or society for any kind of civic betterment you will find that the large proportion of the men are graduates of colleges. In the unpaid service of this city I should say that fully 60 per cent. on any list are the names of graduates of colleges. A notable achievement soon to be announced in all its fullness, I hope, not later than next fall, the result of the negotiations now proceeding for the establishment at the Hague of a supreme court of the world, is the work of lawyers. The Secretary of State has already announced that it will succeed. We understand that Great Britain, France, Germany, Italy, Austria and others of the great powers have acquiesced. We may confidently look forward to the announcement in the fall or in the winter that by 1912 such a court will be opened, with the support of all the great governments of the world and with the prospect that the character of its judges and the character of its decisions will draw the adherence of

all the other nations, including those small nations which could not be fully represented on such a court without making its size unwieldy. That project is a project of the lawyers of this country. It is true it was the dream of William Penn and Elihu Burritt and many other men, but the men who have made it a practical certainty are lawyers, like the present Secretary of State, like Elihu Root. It is that kind of service, gentlemen, which may become possible for any one of you, that which is honor enough for any man, whether his name is ever publicly linked with it or not. It is that you would be on the lookout for any opportunity that may lead to such public service. I do not mean holding office, necessarily, though it may be your duty to do that—an expensive luxury. It may be your duty to be an honest manager in politics. I am talking about doing your part in unfailing and intelligent public service, and chiefly by informing the public opinion of your state and country and of the world! And to give your support to every great project that makes for the permanent improvement of this world. That, gentlemen, will justify all that has been expended upon you by your parents, by your friends, by the university, by the state, by the men who gave their lives for progress, the men so honored of this city and the men so honored in every city, who gave their lives that we might have the rich heritage that we enjoy today. May no man be snared by the thought that all the great deeds have been done and we have come to the end of the heroic years; that the only thing to do is to get as much money as quickly as possible and spend it on ourselves.

Remember what Richard Watson Gilder wrote in his sonnet on the Heroic Age:

He doth not well who doth his time deplore,  
Naming it new and little and obscure,  
Ignoble and unfit for lofty deeds.  
All times were modern in the time of them, and this no  
more than others.  
Do thine own part here in the living day,  
As did the great who made old times immortal.  
So shall men, looking back to this far-loomed hour,  
Say, then the time when men were truly great.  
Though wars grew less, their spirits met the test of new  
conditions;  
Conquering civic wrong, saving the State anew by virtuous lives.  
Guarding their country's honor as their own, and their  
own as their country's and their son's,  
Defying leagued fraud with single truth;  
Not fearing loss and daring to be pure.  
When error through the land raged like a pest,

They calmed the madness, caught from mind to mind,  
By wisdom drawn from old and counsel sane.  
And as the martyrs of the ancient world, gave death for  
man,  
So nobly gave they life.  
Those, the great days, and that, the heroic age.

The heroic age is always present, and heroic men can always do heroic deeds. You have the same opportunity as those who have gone before. De Tocqueville, acute observer as he was, made the mistake of saying early in the last century after going over our country that we were turning our backs on our ideals; that the spirit of 1776 was disappearing; that we were becoming a nation of land-grabbers, taking government land by hook or crook; making haste to get rich, becoming more and more materialists, and that we could never again respond to the appeal of the ideal. Then came the Civil War and gave the lie to all his predictions. Men of the North and men of the South alike responded to the appeal of the ideal with their lives. One-half million of them died and twice as many were crippled for life. Just such men as you are for the most part, many younger, gave up not only the opportunity of making money and other forms of material success, but gave up home, father, mother, wife, sweetheart, that they might pour out their lives upon the altar of their ideals. In Illinois one man out of seven went to the war; in Kansas one out of six; in Louisiana one out of five; in North and South Carolina, nearly 20,000 more men than were voters in the two States. Gentlemen, we are of the same blood, and would make the same response. We are materialists, but we are also idealists. We do love money and the things money will buy, and we want it, not entirely for ourselves, but we want other things more, and when we have to choose, we shall choose higher things. It is, of course, easier to be a hero in war than in peace, but peace hath her victories and heroes no less than war. Every day and all around us men and women are living heroic lives, full of courage, the cheerful, smiling courage of the finest battlefield soldier, and often under more trying conditions than soldiers ever have to face. The great work of the world is being carried on; great things are being done, and a million little things in a great spirit. We may serve our country now just as effectively as in time of war.

William James has been asking for something which would inspire us with a stimulus that would be the moral equivalent of war. What greater

stimulus do we need than the appeal of our country and of our time, to our loyalty and fidelity. Can we not say in Lowell's words:

"Oh beautiful my country! What were our lives without thee? What all our lives to save thee?" And then, "We shall live for thee."

Because we believe in you on this, the great day of your scholastic life, and you will never have another upon which your ideals will burn brighter before you, we have confidence that you will make such response on this commencement day, happy name. As your relatives and your friends, perhaps with tears in their eyes, perhaps after many sacrifices, look upon you at this starting line, as we who are strangers except in sympathy, see you enter in the great race, all of us believe that you see the highest possibilities, the great goal and that you will not be content with less.

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ADDRESS DELIVERED TO THE GRADUATING CLASS OF THE UNIVERSITY HOSPITAL TRAINING SCHOOL FOR NURSES.\*

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By ARTHUR M. SHIPLEY, M.D.

---

A nurse's life is a life given to service, and because of this I have taken as a sort of text some lines of Leigh Hunt—a little poem entitled "Abou Ben Adhem":

"Abou Ben Adhem (may his tribe increase)  
Awoke one night from a sweet dream of peace,  
And saw within the moonlight in his room,  
Making it rich and like a lily in bloom,  
An angel writing in a book of gold.  
Exceeding peace had made Ben Adhem bold,  
And to the presence in the room he said:  
'What writest thou?' The angel raised its head,  
And with a look made all of sweet accord  
Answered, 'The names of those who love the Lord.'  
'And is mine one?' said Abou. 'Nay, not so,'  
Replied the angel. Abou spoke more low,  
But cheerly still; and said, 'I pray thee then  
Write me as one that loves his fellow-men.'

"The angel wrote and vanished. The next night  
It came again with a great wakening light  
And showed the names whom love of God had blessed,  
And lo! Ben Adhem's name led all the rest."

And so your life is to be given to service, and in that it does not differ very markedly from the lives of the rest of us. Most lives are given to service of one sort or another. It is the kind of

service that makes this difference. There are those of us who serve our lives out to love of money, or love of power or love of fame, and some there are who serve only at the altar of pleasure, and some who follow blindly any will o' the wisp, but you have chosen a service to your fellow-man, and it is a right wise and satisfying choice.

You are about to begin an old life in a new way. You are about to begin to practice what you have learned, but under changed conditions. However much you may have rebelled at different things during your hospital residence, you are going to miss it all. You will miss the advice of those who have often advised you against your will, perhaps, but most of all you will miss the association with one another. You do not realize how you have grown into each others' lives and thoughts. As the years slip by you will forget some of the unpleasant things and remember the comforting things. Be loyal always to your class and your school. Associate yourself with its graduates. Return as often as possible and renew old acquaintances. Lend your advice and encouragement to those who are traveling the road you know so well. The future of your training school depends to some extent on what you shall say and do. Praise if you can. Criticise if you must, but make your criticism in a manner that will be helpful.

Your success as a nurse will depend largely upon two things—first, as to what impression you make upon physicians, and second, as to how you impress your patients and their relatives. Now the physician and the patient will judge you by different standards very largely. The physician will be guided in his opinion of you by the manner in which you do your work, by your professional attitude, by the skill you show in carrying out his directions. The patient will judge you by other standards. He will be influenced largely by your personality and character. He will have no way of judging your technical skill, but he will find out very soon what manner of person you are; so it behooves you to remember that you are both a nurse and an individual. You should endeavor to be just as proficient in the one as in the other.

The art of nursing is as old as the race itself, and it has been always the duty of women to nurse the sick and to comfort the anguished. It

is instinctive in us to turn to womankind for solace when we are distressed. It begins when we are small children. At the slightest hurt it is to our mothers or aunts or older sisters that we hasten for sympathy. And so, whatever may be said about the wisdom of women entering into the various occupations of life, all are agreed that nursing is essentially a woman's work. Who but women have the patience and the tact, the long suffering and the gentleness to be nurses. While the art of nursing is an old one, the trained nurse is a product of the last fifty years. It is to Florence Nightingale that most credit is due. She began the organization and training of nurses at St. Thomas' Hospital, in London, in 1853. It was not until 1872 that the first class of trained nurses in this country was graduated from Bellevue Hospital, in New York city. From this very recent beginning the nurse has become almost as important a factor in the treatment of disease as is the physician himself. You have chosen a splendid work. You have entered upon a life that is full of the possibility of growth and usefulness. You are already recognized as one of the blessings of the age. Man is often uncertain as to his need for education, or even religion, but there is no doubt in his mind as to his urgent need for help when he is ill. You are trained for the helping, and I believe you will come very near to happiness and peace of mind in your calling—that you will come as near to finding these things as any of us, and very much nearer than many.

Let us analyze for a moment some of the objects of life. What are the things that we want? Many of us have rather vague ideas about it. If the good fairy of the story books of our childhood should appear suddenly before us and give us three wishes, what would those wishes be? It is fair to assume that most of us would include in these three—happiness. One of the definitions of life is the pursuit of happiness. Now happiness is a vague and uncertain thing, and for most of us dwells always in the next country.

Let us see then how the practice of your profession makes for happiness. You should be most happy in the possession of a life work. Work is the greatest medicine in the world. If it were not for work our asylums and sanitariums would be full to overflowing. It is the thing that keeps us steady and sane and clear-headed. Pick up any paper in any city during any day in any

year and you will notice that nearly all of the foolishness and a good majority of the vice are the doings of the idle. To have found a life work, to be able to do it well, and to be happy in the doing is about as near to the Islands of the Blessed as we may hope to get during the years of the life that now is.

There is much prospect of happiness in the opportunities of your calling. No matter where your work shall take you, you have a wonderful chance to preach the gospel of hope and cheerfulness and right thinking. Not preaching it by word of mouth, Heaven forbid, but preaching it by your conduct. You may, if you will, easily become moral lighthouses on a dark and stormy sea.

Then you may become an educational force. Teaching is one of the great joys of life. If you do not believe it, look for a moment at the thousands of teachers scattered through the world who are devoting their lives to instructing others, a devotion that can in no sense be measured by the salaries paid. There is more unpaid effort expended in the teaching of the children and grown-ups of the world than in any other one thing. Think of the millions of mothers who teach their children, the thousands of religious institutions where teaching is done, the tens of thousands of lives devoted partially or wholly to charity, and teaching is the fundamental principle of all charities, and you will readily see how easy it is for you to become teachers also. It is not only your opportunity, but your duty to teach by example how things should be done. You may become teachers of cleanliness. Mankind is far from being clean. The great sciences of Hygiene and Preventive Medicine are largely a matter of cleanliness. We are all by nature imitators, and you can scarcely go into a home and remain for any time without exerting an influence. Don't think it is your duty always to tell people that their way is wrong. Just simply show them how beautiful a thing is cleanliness.

Your life work is going to bring you into a peculiarly intimate relationship with all kinds of people. Some of these will help and improve you, and some will need your help and counsel. You are going into homes at a time of anxiety and disturbance, and oftentimes anguish. You are going to help and not to hinder. Don't forget that. It is going to be your duty to slip into the lives of people, to hide with them for a period, and

then slip out again. On the manner of your coming and your going rests the reputation of your craft. You can't possibly be so good a nurse as to make folks forget that you are not a good woman. You have in your keeping the reputation not only of nurses, but of womankind as well. It is your duty to make of your self-respect a sort of idol and to bow down before it night and morning all your life long. Your work will give you glimpses of the naked human soul, and from this vision you will oft recoil. Time and again you will go down with your patients to the very brink of the river whose name is Death, and the absence, so often, of anything spiritual in the manner of their dying will be mightily disturbing to those of you who ponder things. Still, in spite of all this, don't be morose. Don't let the serious side of it disturb your balance. Think seriously, but be cheerful. You know that serious people are often most uniformly cheerful.

So a large part of your equipment in the practice of your profession should be cheerfulness. The most welcome person anywhere is the cheerful one. You have no idea what a tonic a quietly cheerful person is to those who are sick. Don't let the little wrongs disturb you, and above all, don't think that the world is coming to an end because things are not done your way. There are many good ways often of doing the same thing. So carry cheerfulness with you along with your thermometer, and the one will lessen the need for the other.

Now just a word about old customs and old morals as compared with the new. When we are young we are radical. We don't believe in things, or we believe that they should be different. We do not see any sense in a certain custom. We think we have been ordained to overturn the world, and so we set gaily out to smash things. We refuse absolutely to bow down to the "god of things as they are," and we become converts to the "god of things as they ought to be." And so we give our parents and our older friends much anxiety.

It is not until we are older and wiser that it begins to dawn upon us just how foolish we have been. It is then that we realize that the customs and morals of the world are not the product of one day or even one century, but have been worked out through the years by thousands of men earnestly seeking for the right, that they are

the results of the combined experiences of the generations of mankind since our forefathers first walked the earth. Having learned this lesson we become orthodox again. Now your manner of life is going to take you away from home influences. You are already probably looking forward eagerly to a wide liberty of thought and action. The world is full of half-baked creeds and isms of all sorts. Just now women seem to be most affected by them. This is probably because womankind is experiencing a fuller liberty than they have ever known, and like children out of school after a long session they do not know what mischief to get into next. Don't take any of these things too seriously, and above all, don't take yourself too seriously. Don't adopt the first new thing that comes along as your creed and then proceed to preach this new doctrine wherever you go. There is no worse bore on the face of the good green earth than such a person.

Try to be simple and natural and kind and good. In this business of being a nurse don't forget to be a woman—the kind of woman your mother would want you to be. There is no particular demand in the world at the present time for cleverness or brilliancy, but there is a great demand for steadfast and dependable persons. Be natural. Have you ever noticed that our great Gothic cathedrals are only attempts on our part to build something that resembles the tall trees of the forest, where in old days our ancestors gathered to worship? The great writers of music have striven to reproduce the sounds heard in the natural world about us—the voice of the ocean, the music of birds, the wind, the rain, and on their success rests their fame. The great scientists have done nothing more than to attempt to read correctly the meaning of the phenomena of the things about us. One man explained so common a thing as the falling of an apple to the earth and is for all time one of the immortalsthereby. Another, a physician, explained so universal a thing as the circulation of the blood, and because of that is the father of physiology. Another, also a physician, working in far-off Asia Minor and Greece, and living on the very threshold of civilization, wrote down in a simple manner what he saw and knew, and is known as the father of medicine.

Those who have seen farthest into the mysteries of life are most simple and natural and humble. So don't set yourselves up with pride in your

knowledge. It is a big, big world, and we are a very small part of it all.

One of the gravest dangers to you is the drift toward materialism and away from the things of the spirit, imagination, hope, enthusiasm, faith and charity. Your horizon is very apt to become narrow. You forget to read, or if you read, you do so only for amusement. You forget that the divine spark burns brightly in only a few persons scattered here and there in the life of the race, and these have written down for the benefit of those who live after them what they have seen, and felt and heard. They have striven to keep the flame alive through the years. So that it is only by reading and pondering what is read that we who are made of ordinary clay may from time to time get a glimpse of the light of it and feel its warmth.

Take enthusiasm, for instance. Enthusiasm is purely a thing of the spirit. It exists only in the brain of man. It is in no sense a material thing. It can't be valued by our modern craze to reduce everything to dollars and cents. It can't be measured or weighed or bought or sold, and yet it is a priceless thing—one of the most powerful moving forces in the affairs of men, and one of the most attractive of personal gifts. What was it, do you suppose, that made Queen Isabella pawn her jewels in order to aid a mad adventurer in a crazy quest? And then, when his three small ships had steadfastly set their sails westward and had gone far beyond the bounds of the world as then known, what was it kept his superstitious sailors from turning back to home and Spain? Nothing but the sheer influence of the unbounded faith and enthusiasm of one man.

If you would have a clear idea of the power of the spiritual in the world, consider the life of Joan of Arc. Born and reared near the great forest of Domremy, she had communed with the spirits that were supposed to dwell in that great woods 18 miles deep to the center. During this time France was almost entirely in the hands of the English, and a cowardly king, still uncrowned, was on her throne. This young girl, entirely ignorant of any knowledge of warfare, and knowing nothing of the ways of the world, put herself at the head of the French and in a short time raised sieges, won battles, reclaimed most of France and crowned the king at Rheims. Then she went to a martyr's death, but one of the great miracles of history had been performed. How? Because of the influ-

ence of the enthusiasm and faith in her cause of one little peasant maid. There is nothing more attractive than faith in your work, and, after all, you can ask no greater good than to have found your calling and to be content in it. It was Lord Bacon who said: Blessed is he who has found his work. Let him ask no greater blessing."

In behalf of the university and its teaching bodies, in behalf of the hospital staff, and for myself, I wish you good luck and bid you godspeed.

#### RESPONSE TO TOAST TO CLASS OF 1910.

By FRANK PAUL FIREY, M.D., *President.* \*

*Mr. Toastmaster and Brother Members of the Alumni Association of the University of Maryland:*

As the humble organ of my class it is with the greatest pleasure that I arise before you upon this sublime and most momentous occasion. A notice was received by me only a short while ago from our honorable chairman, Dr. Taneyhill, of the role I would be called on to assume this night. Beyond thanking the Alumni Association, to whose generosity we are indebted for this most pleasant event, I hardly feel myself capable of replying to your request to make a speech, recognizing my inability as a speechmaker and that it would be useless for me to attempt to say anything that would be of interest or entertaining to men of such recognized ability and noble achievements as are assembled here tonight. It is, however, gratifying to me to have the honor of representing my fellow-classmates in this capacity. For four long years have we trodden the weary paths of toil with the pleasant anticipation of this our maiden banquet. Many have been our obstacles, and rugged has been our path, but by the guidance and ever untiring efforts of our esteemed instructors, these difficulties have been surmounted. The brilliant and beneficent achievements of our noble forefathers, the pioneers of medicine, have been a most helpful and wholesome inspiration to us. Our institution in the past has been pre-eminent, is at present among

\*Delivered before Medical Alumni Association, June 1, 1910.

the foremost, and we feel confident that in the future will always be second to none.

Mr. Toastmaster, it fills our hearts with gratitude to be enrolled among your number tonight. As I listened this afternoon and tonight to those most eloquent addresses I became conscious of a deeper and I believe broader view of our indebtedness to our alma mater than I before possessed, and it would make me happy if I could now make that new vision permanent by expressing it in words, for indeed she has been given nothing beyond her dues.

What greater delight could we desire than the grand inspirations that have come to us tonight, and we are indeed thankful for the privilege that we as alumni of the University of Maryland are entitled to join in fraternal companionship with those who already bear that much cherished distinction. We this day have received our degree as "Doctors of Medicine" from this distinguished institution, and may we with life and honor and everything else within our power strive to wave the banner of our dear old alma mater higher and higher to the skies, for upon her we feel that the searchlight of fame is forever focused.

And now, dearly beloved classmates, gladness is changed to sadness when each of us to the other says good-by, but though we are separated in the flesh, may our hearts ever be bound together as with hoops of steel, and—

Sweet will be our memories  
In looking o'er the happy autumn fields  
And thinking of the days that are no more.

Dr. Gideon McD. Van Poole, class of 1899, Captain, U. S. A., Medical Department, has been detailed as chief surgeon during the military tournament at Chicago during the month of July, 1910.

Dr. William Royal Stokes, class of 1891, and Mrs. Stokes will close their city home on July 1 and spend the summer at Berg Ainwick, Ellicott City, Md.

Dr. William Cole Davis, class of 1908, First Lieutenant, Medical Reserve Corps, U. S. A., having completed the course at the Army Medical School, has been ordered to Fort Ethan Allen, Vermont, Department of the East.

## CONTINUATION OF ARTICLE ON TRAINING OF MEDICAL STUDENTS FOR OBSERVATION AND RECORDING OF CLINICAL CASES.

By J. C. HEMMETER, M.D., Ph.D., etc.

### A CASE OF MYASTHENIA GASTRICA. PREPARED FOR THE CLINIC OF PROF. JOHN C. HEMMETER, M. D., LL.D.

By H. M. FOSTER, *Cand. Med.*,  
and

R. L. KENNEDY, *Cand. Med.*

*Name.*—S. K.

*Age.*—Twenty-five years.

*Occupation.*—Vendor.

*Race.*—White.

*Social Relation.*—Single.

*Complaint.*—Difficulty and distress of digestion.

*Family History.*—Mother living and in good health. Father dead of typhoid fever. Has four sisters living and well; also, four brothers living and well; has one sister dead from unknown cause; and a brother dead from an accident.

*Negative History* for tuberculosis, lues, malignancy, heart, lung and kidney diseases.

*Past History.*—He was an abnormally small child and had to be kept in an incubator to sustain his life. After this as he grew up he was a very strong and healthy child. He said that he suffered with scrofula from the age of three to the fifteenth year; he also has a bad cataract on his right eye, which has completely destroyed the eye. He says that he is near-sighted in his left eye, and that he has had a cataract on this (left) eye while a child. He has had gonorrhea once, and la grippe every year.

*Habits.*—Very seldom drinks beer or whiskey; smokes moderately; bowels constipated; bladder symptoms absent; sleeps good at nights; has a poor appetite.

*Present Illness.*—For the past six months he has been suffering with costiveness; poor appetite; occasionally nausea and vomiting; little pain in epigastrium; his head has never ached, nor has he any lung, heart, urinary or nervous

symptoms. He has been taking salts and other medicines to keep his bowels open, but they have not improved him in any way, for he says that he feels as bad now as he was six months ago.

He thinks that his condition is due to not being regular in eating his meals and going to stool, for up to six months ago he was in pretty good condition.

*Physical Examination.*—He has a good growth of hair on a well-formed head; no disturbances of the cranial nerves; nose normal; the nasopharynx is a little inflamed; tongue is coated with a brownish fur; teeth, that are present, are in a fair state of preservation; neck shows no palpable glands, abnormal pulsations or tracheal tugging; skin feels about normal, but is very loose; the musculature is very flabby, but not atrophied.

*Thorax.*—There is nothing of particular importance shown upon inspection, both sides of the chest working in unison, there being no areas of pulsation present, including the apex beat. The supraclavicular fossæ being slightly depressed, particularly on the right side.

*Palpation.*—There is no thrill, friction rubs are absent, nor could we feel the apex beat. There is no episternal pulsation, and tactile fremitus is normal.

*Percussion.*—The percussion of the back revealed no abnormal condition, there being normal resonance throughout the lung area. In front the percussion note was also not impaired from about an inch and a half above the clavicles to the beginning of the heart dullness in the third interspaces on the left side, and to the liver dullness on the right side in the fifth interspaces. There was no enlargement of the heart to be noted upon percussion.

*Auscultation.*—Upon examining the heart we found a slow, steadily beating organ, there being no murmurs present or accentuation, but the sounds seemed either distant or very weak. The lungs showed no areas of consolidation or cavity formation. There were no rales or exaggerated respiratory sounds present; vocal fremitus was normal.

*Abdomen.*—Inspection showed nothing of interest, there being no pulsations, tumors or other abnormal conditions present. Percussion brought out tympany over the entire abdomen, more marked in the epigastric region and to below the umbilicus.

*Palpation.*—This was not of much service, for he was extremely ticklish and would, therefore, keep his belly walls so rigid that we were unable to get anything out of it. We inflated his stomach and found it to be in about normal position; the greater curvature being about one and a half to two inches above the umbilicus.

*Examination of Feces.*—It was negative in every particular. Digestion of proteids, carbohydrates and fats as evidenced by proper tests appeared normal in the stool.

*Examination of Blood.*—Hemoglobin test, 90 per cent.; erythrocytes, 4,850,000; leucocytes, 5,400—normal.

*Examination of Gastric Contents.*—We obtained about ten cubic centimeters of the test meal, and after filtration we found that he had a free hydrochloric acid of 18°, and a total acidity of 38°. For the past two days his stomach has been washed out and there has been found at both times some mucus and a great deal of undigested food, particles of which he claims to have eaten three to five hours sooner, and today some reddish debris came up, which, on examination, was found to be parts of an apple he ate last night.

Microscopic examination of the gastric contents revealed neither Oppler boas bacilli or sarcine or other important features.

*Urinary Examination.*—Macroscopically, it was a deep amber color, and of very aromatic odor, but clear.

Microscopically, there are no hyaline casts present, and only a few leucocytes, mucus, and crystals present. It was negative for both sugar and albumen. Total quantity, 48 oz. Spec grav., 1022.

*Diagnosis.*—Is motor insufficiency of the first degree, mysthenia or gastric atony, with a hypochlorhydria associated with it, and a chronic gastritis?

*Etiology.*—Most likely brought on by insufficient mastication, hasty eating and deglutition, though many of the infections discussed may predispose to it such as influenza, which he has every year; but he has not had typhoid fever, malaria and numerous other diseases, including tuberculosis, anemias and various other maladies.

#### TREATMENT.

*Dietetic.*—He should eat two moderate meals widely separated apart, or eat every three hours,

but of exceeding small quantity at a time. His meals should consist, at present, of two eggs, glass of milk, bread and butter, then wait until he feels that the stomach is empty and has desire for more food; after this the light meats and vegetables may be added until he has attained his normal diet. Liquids should be restricted as much as possible. Detailed dietary is omitted for lack of space.

The constipation that is usually associated, as in this case, can be successfully combated by the addition of tomatoes, asparagus, peas, beans, prunes, figs, buttermilk and numerous other laxative agents, which, however, may not be tolerated by his stomach, the diet indicated for his obstipation is for the present contraindicated by the state of his stomach. If this does not work, you may have to resort to cascara, sagrada or aloes, but you usually get the desired results by the drinking of a pint of cold water before breakfast, preferably Bedford magnesia spring water, accompanied by going regularly to stool, massage and the above mentioned dietetic aids. The patient should never drink large quantities of fluids, for in this condition the most of it remains unabsorbed; if the thirst is severe relieve it by rectal enema.

*Lavage.*—This is very important in the treatment and it should be done about three times a week for a time, consisting of hot and cold water in which sodium chloride ( $\frac{5}{i}$  to  $\frac{5}{i}$ ) should be used. This is often followed by marked improvement in the motility of the stomach, also the glandular secretions. The sinus ordeal current with interruption per second, applied intragastrically and gastric massage, have proven efficacious.

*Medicinal.*—While important, is rather insignificant compared to the above mentioned instructions. Arsenic and iron as the most appropriate drugs should be given for their general constitutional effect; and tincture nux vomica and tincture gentian comp. should be given as stomachics to generally tone up the organ, aiding in the treatment by improving the glandular secretion and the tonicity of the stomach walls.

*Discussion.*—The conference between the class and the teacher in this case turned around the question of what diet should be given when a patient presented two abnormal conditions of the digestive tract, one of the stomach (chronic gastritis) and the other of the colon (obstipation),

and where the condition of the stomach directly contraindicated the coarse and stimulating diet best suited for atonic obstipation. The debate that ensued concluded that inasmuch as the stomach condition was more readily curable and ought to be cured first, the diet should be that for gastric atony and gastritis—in the meanwhile the bowels should be kept regular by oil retention enemata. After the gastritis was cured the obstipation diet should be prescribed if it was still necessary, but coarse food still be avoided.

#### REPORT OF A CASE OF CHRONIC GASTRITIS ANACIDIA. PREPARED FOR THE CLINIC OF PROF. JOHN C. HEMMETER, M. D., LL.D.

By GEORGE S. CONDIT, *Cand. Med.*

Name, A. B.; address, Baltimore, Md.; female, married, age 55, nationality, German.

*Family History.*—Father died at the age of 70; cause of death, gall stones. Mother died at the age of 35; cause of death, child-birth. Patient has one child living and well. Three children died very young, cause of death not known. One died at the age of 24; cause of death, epilepsy.

*Past History.*—Negative as to infectious diseases; had liver trouble sixteen years ago; has had stomach trouble for eight years.

*Present Condition.*—Patient complains of pain and fullness in the epigastric region; also, occasional pains in all regions of the abdomen and sometimes in the back. Pain in the epigastric region is constant, but worse after eating; also bitter eructations after eating. Has a desire for food, but when taken it tastes sour; she drinks very little water, has headache nearly all the time; sleeps fairly well; has some nervousness. Vomits some, but not often. Vomitus contains no appreciable amount of blood, but is sour and contains much mucus; bowels are always constipated.

*Physical Examination.*—Patient is rather stout, not emaciated and does not appear to be anemic. Teeth are in very bad condition, only having two; heart and lungs negative; liver dullness slightly increased, extending from the fifth intercostal space to about an inch and a half below the lower rib; stomach slightly extended.

*Urinalysis.*—Shows a small amount of albumin; sugar negative; acetone negative; diacetic acid negative. Sediment shows the presence of uric acid and calcium oxilate crystals, and a few granular and cell casts.

*Test Meal Given December 22, 1909.*—Ewald given at 8 A. M., Boas-Ewald at 11 A. M., drawn at 12.30. Amount obtained, 20 c. c. Appeared to be very poorly digested; showed no free HCl. Combined acidity, 16 (probably due to acid taken with the test meal).

On December 29 a second test meal was given and the same condition found, except total acidity was  $7\frac{1}{2}$ . No free HCl. No lactic acid by Uffelman's test, HCl deficit, 32.

*Diagnosis.*—Chronic gastritis, due to poor mastication and poor diet. Diet of steak made of scraped beef and mashed potatoes. Soft boiled eggs and toast for lunch. Bread, cold ham, beef tongue for supper.

*Treatment.*—Hydrochloric acid and nux vomica. Lavage recommended the stomach box regularly for treatment. February 1, decidedly better, though still not free HCl, but HCl deficit less.

*Measurements.*—Height, 5 feet and 1 inch; circumference at xiphoid, 38 inches; manubrium to xiphoid, 9 inches; manubrium to umbilicus, 15 inches; umbilicus to symphysis, 5 inches; xiphoid to right superior spine,  $11\frac{1}{2}$  inches; xiphoid to left superior spine,  $11\frac{1}{2}$  inches; xiphoid angle,  $80^\circ$ .

#### A CASE OF NEURASTHENIA GASTRICA. PREPARED FOR THE CLINIC OF PROF. JOHN C. HEMMETER, M.D., PH.D., LL.D.

By MICHAEL S. HANNA, Cand. Med.

UNIVERSITY HOSPITAL, January 8, 1910.

Dispensary Case No. 17880.

*Name.*—H. S.

*Address.*—Baltimore.

*Age.*—Twenty-five.

*Color.*—White.

*Sex.*—Male.

*Social Condition.*—Single.

*Occupation.*—Janitor in a tobacco factory.

*Complaint.*—“Pain in epigastrium and precordia.”

*Hereditary Facts of Importance.*—Father died of heart disease.

*Previous History.*—Patient had measles and scarlet fever. He also had inguinal buboes that persisted for a long time and for which he was given different drugs internally.

Always constipated.

Drinks and smokes in excess.

*Present History.*—Five weeks ago patient felt a dull pain of a somewhat burning character in the epigastrium, not well localized, which pain often invaded the precordia and settled there for a more or less prolonged period of time, then disappeared without any treatment.

Patient was taken with that pain at irregular intervals during the whole of that week. It then disappeared for about two weeks and recurred.

*Character of Pain.*—Dull, burning, occurring mostly at about two to four hours after meals and decreased in severity by the use of some anti-acid mixture.

*Local Subjective Symptoms.*—Fullness in epigastrium; a little nervousness; a little headache; constant constipation; interrupted sleep; choking sensation in throat sometime during the act of swallowing; loss of nine pounds of weight in the last month.

*Physical Examination.*—Patient is fairly developed, but poorly nourished. Head, ears and eyes are in good condition, with the exception that the conjunctiva is a little pale. Tongue slightly coated and fissured, especially the posterior part of it. Teeth in a defective condition.

*Inspection.*—Chest—Left costal cartilages are more prominent than those of the right side. Tenth left rib is detached and its anterior end is clearly seen. Abdomen slightly concave.

*Palpation.*—Reveals small palpable gland in base of right side of neck; also in oxilla. Palpation confirms the detachment of the left tenth rib. Xyphoid cartilage is absent. Tenderness on pressure in epigastrium, three fingers below sternum. Nothing abnormal in any of the abdominal viscera.

*Percussion.*—Normal on chest and heart area. The inferior boundary of the stomach is two fingers above the umbilicus. Liver and spleen are

normal in position. The abdomen gives a slightly exaggerated tympany.

*Auscultation.*—First sound of heart is weakened.

*Nervous System Examination.*—Nothing particular except a slight general irritability.

*Measurement.*—Xyphoid angle, 85°, measured by graded sector. Distance from xyphoid to umbilicus, 7½ inches. Distance from umbilicus to symphysis pubis, 7 inches. Distance from xyphoid to left ant. sup. sp. of ilium, 11 inches. Distance from xyphoid to right ant. sup. sp. of ilium, 11 inches. Circumference at xyphoid, 30½ inches. Hemoglobin, 85%.

*Test Meal Examination.*—Amount, 80 c. c. Grayish white in color with bread particles. Very little mucus.

*Chemical Examination.*—Reaction, acid. Free HCl 48°. Total acidity, 60°.

*Urinalysis.*—Amount in 24 hours, 1400 c. c. Very clear, straw color, sp. gr., 1020. Reaction, alkaline. Albumen and sugar, negative. A very few hyaline casts and a little mucus. Total solids, 46.60 grams.

*Diagnosis.*—Neurasthenia gastrica (nervous dyspepsia) of the hyperacidity type.

*Treatment (of this patient).*—First is moderation or even stoppage of drinking alcoholics, and decreasing the amount of tobacco he smokes.

A change in occupation, if possible, or getting a position in another department of the same factory which is not much exposed to tobacco dust.

Rest as much as possible, both mentally and physically.

Good hygienic surroundings.

Cold sponge bath in the morning for three minutes, during which his muscles should be kneaded, then wipe dry.

If patient can help by coming every second day to the dispensary an intragastric douche of carbonate water to the stomach may be used with some advantage in lessening the hyperesthesia of the mucous membrane.

*Dict.*—Milk is best of all to be associated with articles of food that patient likes, but which suit his condition, such as rice, boiled potatoes, eggs, soups; fruits, such as apples, for they have a good laxative property. He should stop any article that does not agree with his condition. Olive oil

butter is well to be recommended both for his obstipation, and also because fats arrest the secretion of HCl to a certain extent.

*Drugs.*—I prescribed for him a tonic and gave him bromides to lessen the irritability of his nervous system.

The following prescriptions are to be recommended:

Strychnia Sulph., gr. 1-30.

Ext. Rhei, q. s.

M. and fiont fiat, Pilula No. 1, 30.

Sig. one t. i. d.

The Rhei ext. is given here to act as a laxative.

R. Potass. bromide,	} 5 <i>iii.</i>
Amm. bromide,	
Sod. bromide,	
Syrup Auranti. cortex, 5 <i>i.</i>	} 5 <i>vi.</i>
Aqua q. s. ad,	
M. fiat solution,	} 5 <i>vi.</i>
Sig. one teaspoonful t. i. d.	

Patient should call on the physician after finishing this medicine for a further treatment.

Alcaline powder, containing equal parts of magnesia vista and sodium bicarbonate, was used in intervals between the bromide treatment.

February 10.—The patient is much improved and has gained weight.

The discussion took for its central point the difficulties in differential diagnosis between a pure neurosis of the stomach and genuine organic gastric diseases. Cases were exhibited that gave all the evidence of both states simultaneously.

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The following have been appointed health officers of Carroll county, Maryland: Dr. Luther Kemp, class of 1887, Uniontown; Dr. John B. F. Weaver, class of 1864, Manchester; Dr. Charles R. Foutz, class of 1897, Westminster; Dr. Edwin De Witt Cronk, class of 1884, Woodbine; Dr. Charles H. Diller, class of 1872, Detour; Dr. George H. Brown, class of 1864, New Windsor; Dr. James H. Watt, class of 1863, Union Bridge, and Dr. William E. Gaver, class of 1888, Mount Airy.

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Prof. and Mrs. Wilbur Fiske Smith of Clifton avenue and 13th street, Walbrook, Md., have announced the engagement of their daughter, Margery Janney Smith, to Dr. Herbert Seth Anderdon, class of 1910, of Tappahannock, Va. The wedding will take place this month.

# THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, Md., JUNE 15, 1910.

## STATE BOARD STATISTICS FOR 1909.

In 1904 the American Medical Association appointed a council on medical education, the duty of which was to collect statistics in regard to medical education in this country and to collate the results of the various examining boards in the country and to present a report yearly at a meeting of the association. Ample funds were appropriated for the use of this council, and a secretary was employed under salary who would devote all his time to the work. Year by year the reports of this council have been published, and whilst errors have naturally crept into the reports, they have on the whole been fair and have given a reasonably correct summary of the work of the different medical colleges of the country. The results of this investigation and collaboration have been wide-reaching and of great benefit to the cause of medical education in the United States. The colleges have been classified into groups according to the percentage obtained by their graduates before the various examining boards. Group A consists of those whose failures are less than 10 per cent., Group B of those with from 10 to 20 per cent. of failures, and Group C, above 20 per cent. The publication of these statistics has been attended with many surprises, and colleges that were supposed to be doing work of a high class have been found woefully lacking. The spreading abroad of these statistics has been very helpful to the various institutions concerned, and those that have desired to do good work have made renewed efforts to overcome their previous failures and to get into a higher class. Not only has the publishing of these statistics had the good effect mentioned above, but it has caused a marked reduction in the medical colleges in this country, and the number of these

institutions has fallen from 166 to 132 by the voluntary extinction of some of the schools, and by the merger of others, so that in several cities two or more schools have voluntarily merged into one, thereby producing one good institution where perhaps there had been previously from two to five poor ones. This reduction in the number of medical schools is bound to continue, and each year we shall see fewer colleges and better equipped ones. The report of the council on medical education has just been published in the *Journal of the American Medical Association*, and is a most interesting document. We find that in Maryland 483 graduates of medicine were examined by the State Examining Board in the year 1909. Of these, 19.7 per cent. failed, or nearly one-fifth. Of those graduating in 1909, 247 appeared before the Maryland Examining Board, with a failure of 15.8 per cent. It is very gratifying to the Faculty of the Medical Department of the University of Maryland to find that of 111 graduates examined last year, 9.9 per cent. only failed to pass the board, and of those graduating between 1905 and 1909, 101 in number, only 8.9 per cent. failed to pass. We are, therefore, placed in class A, the only other Maryland college in the same group being the Johns Hopkins University. Whilst this result is very gratifying, it is necessary for us to take care that we do not rest upon our present good success, but that we redouble our efforts not only to remain in this group, but still further reduce our percentage of failures. Two years ago a new system was introduced in the method of advancing students in the medical department. Previous to that time men were permitted to carry conditions from one year to another, which not only seriously hampered them, but which rendered it impossible for them to continue their work satisfactorily. In the fall of 1908 men who were found to be hampered with a number of conditions were ordered to repeat their course or to go elsewhere. This had a very salutary effect. Some men repeated their courses and were not advanced, and a number of others went to other institutions. We see the effect of this action immediately in the report of the medical council of the results of the examining boards throughout the country. The University of Maryland Medical School is one of the largest schools in the country, being put down fifteenth in the number of graduates examined by the boards last year. Let us see to it, then, that it shall rank amongst the best, not only numerically, but in results.

## University of Maryland Hospital.

## DISPENSARY REPORT.

April 1, 1909, to April 1, 1910.

Department.	New Cases.	Old Cases.	Total	1908-09.
Surgical .....	1610	4300	5910	6151
Medical .....	1402	3167	4569	4958
Genito-Urinary .....	676	2471	3147	3698
Nervous .....	371	1853	2224	2370
Stomach .....	475	1241	1716	1529
Women .....	617	1024	1641	2012
Children .....	696	845	1541	1758
Eye and Ear.....	680	806	1486	1617
Throat and Nose....	550	805	1355	1661
Tuberculosis .....	405	660	1065	893
Orthopedic .....	42	90	132	151
Rectal .....	26	31	57	....
Grand Total.....	7959	17,922	25,881	28,128

JOHN HOUFF, M. D.,  
Dispensary Physician.

## ITEMS

According to the statistics of the various State licensing boards, as published in the *Journal of the American Medical Association*, May 21, 1910, the record of our graduates in 1909 should be a source of much gratification to our faculty, alumni and friends. We are classed with group A, colleges having a mortality of less than 10% of failures. In studying the statistics we note that the percentage of failures before the home and foreign boards was almost identical, to wit: 9.1% for home State, and 8.8% in other States. As we had 111 graduates before the examiners, and these distributed to 20 examining boards, the result obtained is fairly representative of the character of men we are turning out; for as the *Journal of the American Medical Association* states, in arriving at the efficiency of the several colleges, many factors must be taken into consideration. The number examined is important since, if all other conditions are equal, the larger the number of graduates examined, the more accurate the finding. We were fifteenth in point of number examined, therefore we meet this condition admirably. The number of States in which a school's graduates have been examined is im-

portant. The larger this number, the more accurate will be the conclusions. Here again we comply exceedingly well with this specification, as our men were before twenty boards.

Our school complies with all of the factors as postulated by the Council on Medical Education of the American Medical Association entering into the best method of rating the standing of a medical college, namely, in the point of numbers examined in 1909 we stand fifteenth on the list of colleges, having 111 candidates of all years before the boards of twenty States. Of these 9.9% failed; 101 graduates of 1905-1909, inclusive, took the examinations in eighteen States, with a failure percentage of 8.9; and 10 graduates of 1904 and previous before eight boards, with a mortality of 20%; of the 1909 graduates 76 appeared before 13 examining boards, with 10.5% failure.

Whilst this record is not as good as we desire, nor as good as our authorities are determined to make it, yet it is such an improvement over that of previous years that all who have the welfare of the university at heart should feel a tinge of pride in the position of excellence attained by our alma mater. Of the colleges (44) having 50 or more graduates up for examination, our percentage of failure, 8.9, entitles us to occupy the twentieth position in order of excellence. Also the fact of having this small proportion of delinquents places our college in the honor group, class A medical colleges. We also note that in the State of Maryland the Johns Hopkins University and the University of Maryland are the only colleges in the favored group.

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Dr. S. R. Donohue, class of 1902, has been appointed by the Norfolk School Board physical inspector of public school children of Norfolk.

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Dr. Samuel Jackson Price, class of 1909, is located in Baltimore, where he is engaged as a surgeon in the Baltimore & Ohio Railroad Co., Relief Department.

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Dr. Louis M. Allen, class of 1896, has moved to Winchester, Va., where he will take up the practice of the late Dr. Samuel Peachy Latane.

Amongst our alumni residing in Baltimore are:  
Doctors—

William Guy Townsend, 2017 North Charles street.

Solomon Jay Ulman, 1725 Park avenue.

Claude Van Bibber, 9 East Read street.

Eugene McE. Van Ness, 200 West Lafayette avenue.

Mactier Warfield, 700 North Howard street.  
Ridgely Brown Warfield, 845 Park avenue.

Robert A. Warner, 873 West Lombard street.

William Topping Watson, 2128 St. Paul street.

Walter Walton White, Jr., 1101 North Broadway.

William Kelso White, 1818 North Charles street.

William Edward Wiegand, 1101 Madison avenue.

George Lawson Wilkins, 6 North Broadway.

John Whitridge Williams, 1128 Cathedral street.

Henry Merryman Wilson, 1008 Madison avenue.

Lot Ridgeley Wilson, Hollins street and Fulton avenue.

Robert Taylor Wilson, 820 Park avenue.

James Gerard Wiltshire, 819 North Eutaw street.

FitzRandolph Winslow, 1841 Pennsylvania avenue.

John Randolph Winslow, 114 West Franklin street.

Nathan Winslow, 3112 West North avenue.

Randolph Winslow, 1900 Mt. Royal Terrace.

Edward Martin Wise, 706 North Howard street.

Charles S. Woodruff, 823 North Eutaw street.

Hiram Woods, Jr., 842 Park avenue.

Thomas Chew Worthington, 1022 Madison avenue.

James Albert Zepp, 3050 West North avenue.

Herbert Elmo Zepp, 3050 West North avenue.

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Dr. Joshua W. Hering, class of 1855, of Westminster, has been appointed by Governor Crothers as a member of the Public Service Commission.

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Dr. Page Edmunds, class of 1898, discussed a paper on "Railway Injuries to the Spine" at the recent meeting of the Association of Railway Surgeons of the Baltimore & Ohio System, which was held in St. Louis from June 4 to 7.

Dr. Summerfield B. Bond, class of 1883, chief surgeon of the Baltimore & Ohio Railroad, attended the meeting of the Association of Railway Surgeons recently held in St. Louis.

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Dr. Charles Bagley, Jr., class of 1904, has resigned as superintendent of the Hebrew Hospital. Dr. Bagley is a son of Dr. Charles Bagley, of Bagley, Harford county, Maryland, and is 28 years of age. He has been superintendent of the Hebrew Hospital for the past four years. During his administration the hospital has done well, and his work has won the hearty commendation of the trustees. He will enter private practice. Dr. Bagley, as a reward for his faithful and eminent services, has been appointed visiting surgeon to Hebrew Hospital.

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Dr. Charles O'Donovan, class of 1881, and Mrs. O'Donovan have closed their town house and are at Phoenix, Md., for the summer.

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Dr. John Joseph Egan, class of 1907, was stricken with appendicitis June 1 while preparing to attend the commencement exercises of this year's class, at which his friend, Dr. Michael Joseph McDermott, received his diploma.

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Dr. George W. Dobbin, class of 1894, was seriously injured in an automobile accident on Mt. Royal avenue June 2 while on his way to visit a patient. He is now at the Mercy Hospital in a serious condition.

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Dr. Benjamin Kader, class of 1910, was tendered a banquet at the Carrollton Hotel Saturday evening by about 45 employes of the mailing department of the Baltimore city postoffice, where Dr. Kader has been employed for seven years. Dr. Kader was presented with a case of surgical instruments by his friends.

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In the list recently published of University of Maryland alumni residing in Baltimore the name of Dr. Albert T. Chambers, class of 1898, was inadvertently omitted. Dr. Chambers is one of the most prominent of our younger practitioners. We are glad to report to his many friends that Dr. Chambers is Professor of Anatomy in the Maryland Medical College, and that since engaging in the practice of medicine he has been very successful.

Dr. Alexander D. McConachie, class of 1890, was toastmaster at a dinner recently given at the Hotel Stafford by the Faculty and Students of the Maryland Medical College.

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Among recent visitors to the University Hospital were Dr. James Lee Hopkins, class of 1897, of Havre de Grace, Md., and Dr. William L. Mauldin, Jr., class of 1901, of Greenville, S. C.

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Dr. Robert Parke Bay, class of 1905, has resigned his position as superintendent of the University Hospital to engage in the practice of surgery in Baltimore. Dr. Bay is a native of Harford county, Maryland, and has filled with credit successively the positions of house student, assistant resident physician, assistant resident surgeon and acting superintendent of the University Hospital during the absence of Dr. Arthur M. Shipley in Europe, after which he served as superintendent of Bay View Hospital, filling out the unexpired term of Dr. R. R. Norris, also a graduate of the University of Maryland, class of 1904. Dr. Bay was then appointed superintendent of the University Hospital, which position he has held for the past two years. He is one of the most capable of our recent graduates, and has rendered very efficient service to the University in his various capacities at the University Hospital.

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Miss Nannie J. Lackland, a graduate of the University of Maryland Training School for Nurses, has been reappointed secretary of the Maryland State Board of Examiners for Nurses.

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The annual reunion and banquet of the Alumni Association of the University of Maryland School of Medicine was held at the Eutaw House June 1, 1910. The retiring president, Dr. William H. Pearce, class of 1891, made the opening remarks. Dr. A. O. McConachie was toastmaster. Short talks were given by the invited guests, Rev. Romelly F. Humphries, D.D., rector of St. Peter's Protestant Episcopal Church, and Dr. Lewellys F. Barker of Johns Hopkins University, and Dr. Henry F. Carter of the Public Health and Marine Hospital Service. The following officers were elected for the ensuing year:

President—Dr. G. Lane Taneyhill, class of 1865.

Vice-Presidents—Dr. James H. Jarrett, class of 1852; Dr. George H. Hocking, class of 1879; Dr. St. Clair Spruill, class of 1890.

Recording Secretary—Dr. Charles E. Sadtler, class of 1873.

Assistant Recording Secretary—Dr. Nathan Winslow, class of 1901.

Corresponding Secretary—Dr. James M. Craighill, class of 1882.

Treasurer—Dr. John Houff, class of 1900.

Executive Committee—Drs. B. Merrill Hopkinson, class of 1885; John I. Pennington, class of 1869; Charles R. Winterson, class of 1881; Page Edmunds, class of 1898, and Wilmer Brinton, class of 1876.

Dr. George Lane Taneyhill, the new president, has always been a warm admirer of the University, and an indefatigable worker in her interests. For 30 years he filled the office of treasurer of the Medical Alumni Association—from its organization to 1909—when he was succeeded by Dr. John I. Pennington. Dr. Taneyhill was born at Bellefonte, Center county, Pennsylvania, March 11, 1840. He is Bachelor of Arts from Dickinson Seminary, Pennsylvania, 1858, and A.M. Dickinson College, class of 1882, M.D. University of Maryland, class of 1865. He was assistant surgeon Eleventh Maryland Regiment, United States Volunteers, during the Civil War; assistant physician Maryland Hospital for the Insane, 1865 to 1868; president Baltimore Medical Association, 1864-1865; recording secretary Medical and Surgical Faculty of Maryland, 1882-1894; at present surgeon-general of the Grand Army of the Republic. Dr. Taneyhill resides at 1103 Madison avenue, Baltimore.

The retiring officers were: President, Dr. William Herbert Pearce; vice-presidents, Drs. Guy Steele, Joseph Smith and A. C. Pole; recording secretary, Dr. Charles E. Sadtler; assistant recording secretary, Dr. J. F. H. Gorsuch; corresponding secretary, Dr. John Houff; treasurer, Dr. John I. Pennington, and executive committee, Drs. A. D. McConachie, Geo. H. Hocking, C. R. Winterson, B. M. Hopkinson and G. L. Taneyhill.

The subscribers to the banquet were:

Drs. H. C. Algire, Thomas A. Ashby, A. K. Bond, Josiah S. Bowen, Joseph Blum, J. M. Craighill, Eugene F. Cordell, James J. Carroll, Albert T. Chambers, Charles C. Conser, J. Clement Clark, R. P. Carman, Charles M. Chaney, Theo-

dore Cooke, Charles R. Davis, N. S. Dudley, John Dickson, H. C. Davis, Page Edmunds, Samuel T. Earle, Frank C. Eldred, Geo. A. Fleming, Chas. R. Foutz, Charles W. Famous, B. S. French, J. W. Funek, W. H. Fedderman, Joseph E. Giehner, C. B. Henkel, Jose L. Hirsh, C. C. Harris, J. C. Hemmeter, C. W. Heffinger, G. H. Hocking, H. C. Hyde, T. Henry Harrison, W. H. Houston, L. B. Henkel, John Houff, N. F. Hill, H. C. Houck, B. M. Hopkinson, Geo. W. Hemmeter, J. H. Jarrett, H. W. Jones, W. B. Kirk, C. J. Keller, J. T. King, Howard Kalm, G. M. S. Kieffer, W. S. Love, C. H. T. Lowndes, J. W. Linthicum, C. W. Mitchell, A. D. McConachie, J. N. Morris, W. S. Maxwell, H. J. Maldeis, H. L. Naylor, V. L. Norwood, H. N. Naylor, L. E. Neale, H. C. Ohle, J. W. Pillsbury, A. C. Pole, Wm. H. Pearce, John I. Pennington, J. D. Reeder, J. H. Rehberger, I. H. Robinson, E. Miller Reid, J. Tyler Smith, C. Urban Smith, St. Clair Spruill, G. H. Steuart, Howard C. Silver, Joseph T. Smith, Charles E. Sadtler, A. Trego Shertzer, W. A. B. Sellman, L. J. Turlington, G. Lane Taneyhill, Thomas J. Talbott, E. M. Wise, M. B. West, James W. Wilson, FitzR. Winslow, C. R. Winterson, John R. Winslow, Jos. C. Wunder, Nathan Winslow, Hiram Woods, Randolph Winslow, J. A. Zepp, H. E. Zepp, Samuel H. Anderson, B. F. Busey, Thos. E. Blackshear, James P. Carter, Albert H. Carroll, Wirt A. Duvall, Matthew C. Freilinger, M. J. Hanna, Herbert Harlan, G. Carroll Lockard, J. L. Messmore, J. T. O'Mara, I. T. Payne, Compton Riely, I. J. Spear, W. S. Smith.

During the course of the evening the assembly was entertained by solos and duets by Dr. B. Merrill Hopkinson and Mr. Felix A. McNally.

#### THE ONE HUNDRED AND THIRD ANNUAL COMMENCEMENT.

The Annual Commencement of the University of Maryland was held at the Academy of Music Wednesday afternoon, June 1, at 4 o'clock. The order of exercises was as follows:

Overture—"Maritana".....Wallace  
 Ballet—"Egyptian".....Lugini  
 Music—March, "Tannhauser".....Wagner  
 Prayer by Rev. A. B. Kinsolving, D.D.  
 Music—Barcarolle, "Contes de Hoffman".....Offenbach  
 Address to the Graduates, Hon. Henry B. F. Macfarland of Washington, D. C.  
 Music—"American Fantasia".....Herbert  
 Conferring of Degrees by Bernard Carter, LL.D., Provost of the University.

Candidates for the Degrees "Bachelor of Arts" and "Bachelor of Sciences" presented by the Dean of the Faculty of Arts and Sciences.

Candidates for the Degree "Doctor of Medicine" presented by the Dean of the Faculty of Physic.

Candidates for the Degree "Bachelor of Laws" presented by the Dean of the Faculty of Law.

Candidates for the Degree "Doctor of Dental Surgery" presented by the Dean of the Faculty of Dentistry.

Candidates for the Degree "Doctor of Pharmacy" presented by the Dean of the Faculty of Pharmacy.

Conferring of Honorary Degrees.

Music—Waltz, "Faust".....Gounod  
 Award of Prizes.

Music—March, "Coronation".....Meyerbeer

The address of Hon. H. B. F. Macfarland appears on page 61 of this issue of THE BULLETIN. There were 241 graduates. They were presented by the deans of the respective departments, and were classified as follows:

Bachelor of Arts.....	16
Bachelor of Science.....	1
Doctor of Medicine.....	85
Bachelor of Laws.....	60
Doctor of Dental Surgery.....	54
Doctor of Pharmacy.....	25

Students who received degrees are :

##### BACHELOR OF ARTS.

William Linden Allen, Salisbury, Md.  
 William Patrick Anderson, Cecilton, Md.  
 Webster Strayer Blades, Choptank, Md.  
 Cleveland Dean, Wingates, Md.  
 Roscoe Earl Grove, Middletown, Md.  
 Russell Peter Hartle, Chewsville, Md.  
 Edgar Routzahn Hauver, Myersville, Md.  
 Robert Mullineaux Heine, Ellicott City, Md.  
 Leonard Kolmer, Lonaconing, Md.  
 John Francis Lutz, Annapolis, Md.  
 Thomas Brackett Reed Mudd, LaPlata, Md.  
 James Percy Finkerton, Pocomoke City, Md.  
 Conrad Henry Ruhl, Baltimore, Md.  
 Henry Francis Warrenfeltz, Smithsburg, Md.  
 Henry Eugene Wilson, Tilghman, Md.  
 Peter George Zouck, Glyndon, Md.

##### BACHELOR OF SCIENCE.

Roy Messick Jones, Annapolis, Md.

##### DOCTOR OF MEDICINE.

John Willis Abbott, Virginia.  
 Herbert Seth Anderton, Virginia.  
 John Moody Blodgett, New Hampshire.  
 George Millward Brewer, Pennsylvania.  
 Thomas Brooks y Galo, Cuba.  
 J. Francis Byrne, Connecticut.  
 Morris L. Cahu, Pennsylvania.  
 Giuseppe Caturani, New York.  
 Charles M. Collins, Rhode Island.  
 B. Stover Compton, Virginia.  
 George S. Condit, West Virginia.

## THE HOSPITAL BULLETIN

William Stanislaus Conway, New Jersey.  
 Jaime F. Costas Diaz, Porto Rico.  
 George Cookman Coulbourn, Maryland.  
 Thomas Dalton Crouch, North Carolina.  
 Frederick L. Darrow, Maryland.  
 Clifton Norwood DeVilbiss, Maryland.  
 Roland R. Diller, Maryland.  
 William Barber Fellers, Virginia.  
 Max Joseph Fiery, Maryland.  
 Moses J. Fine, Vermont.  
 Frank Paul Firey, Maryland.  
 James Hudson Fiscus, Pennsylvania.  
 Herbert Melvin Foster, Maryland.  
 Cyril Elmo Fowble, Maryland.  
 Nathaniel Garb, Maryland.  
 Felipe A. Garcia, Porto Rico.  
 William Robert Gardiner, Missouri.  
 Oscar Andrew Gatlin, North Carolina.  
 Samuel Gilman Glover, South Carolina.  
 Charles Alfred Goettling, Jr., Maryland.  
 William Anderson Gracie, Maryland.  
 Michel Samaan Hanna, Egypt.  
 John Trout Herr, Pennsylvania.  
 Maxey Gregg Hoffman, West Virginia.  
 Eugene B. Howle, North Carolina.  
 Anderson Lawrence Hyatt, North Carolina.  
 Benjamin Kader, New York.  
 Robert Lawson Kennedy, Florida.  
 Henry Newton King, South Carolina.  
 Norman Thomas Kirk, Maryland.  
 Erasmus H. Kloman, North Carolina.  
 Louis Winfield Kohn, Maryland.  
 Louie Elsworth Langley, Pennsylvania.  
 Adolphus Lamar Little, North Carolina.  
 Robert Jones Lovill, North Carolina.  
 Alvin Clay McCall, North Carolina.  
 Michael Joseph McDermott, Connecticut.  
 Vernon Hastings McKnight, Maryland.  
 Roscoe Drake McMillan, North Carolina.  
 Chas. Wade McPherson, North Carolina.  
 Alex. R. Mackenzie, Maryland.  
 Alva Adair Matthews, Virginia.  
 Harry Benjamin Messmore, Pennsylvania.  
 James Fremont Might, Pennsylvania.  
 George Blythe Morris, North Carolina.  
 Thomas J. Murray, Connecticut.  
 James Benton Nicholls, North Carolina.  
 John E. O'Neill, Maryland.  
 Maurice E. Broadas Owens, South Carolina.  
 George Albert Parker, Jr., Pennsylvania.  
 William V. Parramore, Georgia.  
 Herbert LeRoy Ransom, Pennsylvania.  
 Dwight Gray Rivers, North Carolina.  
 Joseph Righton Robertson, Georgia.  
 Henry Boyden Rowe, North Carolina.  
 Louis Rubin, Maryland.  
 John Guy Runkel, Wisconsin.  
 Thomas J. Russell, Pennsylvania.  
 Jurgi Elias Sawaya, Syria.  
 Harry Ralph Seelinger, Virginia.  
 Harry A. Shimer, Pennsylvania.

George William Shipp, North Carolina.  
 John Virgil Shull, New Jersey.  
 Napoleon Bryan Steward, Pennsylvania.  
 George Lewis Stickney, Maryland.  
 James Edward Talbott, Maryland.  
 Edmund Hershey Teeter, Illinois.  
 James Archibald Thomason, South Carolina.  
 Ralph Chess Purnell Truitt, Maryland.  
 William Lawrence Van Sant, Virginia.  
 John Henry Von Dreelc, Jr., Maryland.  
 George Walter, Georgia.  
 Murray P. Wichard, North Carolina.  
 Walter Michael Winters, New Jersey.

## PRIZEMAN.

University prize, gold medal, Maurice E. B. Owens.

*Certificates of Honor.*

Napoleon Bryan Steward, Maxey Gregg Hoffman,  
 William Anderson Gracie, Roland R. Diller,  
 Norman Thomas Kirk, Frank Paul Firey.

## BACHELOR OF LAWS.

Emanuel Milton Altfeld,	Robert Henry McCauley,
Emanuel Milton Baum,	Carl Ross McKenrick,
Thomas Gorsuch Campbell,	William C. McSherry,
Richard Bayly Chapman,	Lawrence Vernon Miller,
Austen Bryarly Conn,	Carroll Harper Murray,
Joseph Stanislaus Cook,	Archey Cameron New,
John Coulbourn, Jr.,	John Dix Nock,
Edward Plaskitt Crummer,	Harry Ford Ogden,
William Howard Davenport,	Oliver Owertz Owings,
Edward Joseph Edelen,	George Pitts Raleigh,
Michael Prentiss Feldser,	John Leroy Rebbel,
John Henry Filler,	John Fred'k Requardt, Jr.,
Berkeley Minor Fontaine,	Gordon Elisha Riggan,
William McRea Ford,	Englar McClure Rouzer,
Israel Freeman,	Louis Samuels,
Anthony Joseph Galiner,	Thomas A. Saulsbury,
Frank Gosnell, Jr.,	George Gottlieb Schnepe,
Julius Frederick Guenther,	Theodore H. Schreiber,
Saul Albert Harris,	Henry Elmer Singewald,
Robert Taylor Hoffman,	Jerome Sloman,
Eli Hyman Horwitz,	Jacob Stansberg,
William Carroll Hunter,	James Harry Stelle,
Joseph Hoffman Jacobs,	Enos Smith Stockbridge,
William Harlan P. Jacobs,	Frederick Nelson Tannar,
Harvey Chester Jones,	Richard Lloyd Tilghman,
Reginald Keene,	Kilian Edward Volk,
James Frank Klecka,	Daniel List Warner,
Charles John Koch,	Amos Walter Woodecock,
Charles Osborne Laney,	Charles Carroll Wooden,
Curtis Wailes Long,	Edgar William Young.

## DOCTOR OF DENTAL SURGERY.

Albert J. Allaire, Massachusetts.  
 Frank Robinson Anders, North Carolina.  
 Charles Douglas Ansley, Massachusetts.  
 Nathan E. Austin, New York.  
 Charles DeLacy Bass, North Carolina.  
 Harry Wallace Blaisdell, New Hampshire.

Thomas Lawrence Boyle, New York.  
 Herbert Nathan Brown, Rhode Island.  
 Wallace Burgess Bruce, Maryland.  
 Hugh McK. Burns, Connecticut.  
 Sherley Mingo Callaway, West Virginia.  
 Walter Woods Campbell, Massachusetts.  
 Angelus DeConti, Rhode Island.  
 Arthur Davenport, North Carolina.  
 Richard Warland Davis, Georgia.  
 Andres L. Costas Diaz, Porto Rico.  
 Charles Francis Doud, New York.  
 George C. Downey, Massachusetts.  
 George Clarence Dreher, New Jersey.  
 Roy Jerome Drummond, South Carolina.  
 Davis Groff Everhart, Maryland.  
 Abelardo de Azevedo Falcao, Brazil, South America.  
 Hatney A. Infante Fajardo, Cuba.  
 Henry Holton Flowers, Maryland.  
 Frank Henry Flynn, Maine.  
 Wilbert Diedrich Gieseler, West Virginia.  
 Walton J. Graft, New Jersey.  
 Clarence T. Hamrick, North Carolina.  
 Albert Ackley Harrington, New York.  
 Carl C. Harper, North Carolina.  
 William Lawrence Keller, Maryland.  
 Phares L. Landis, Pennsylvania.  
 John Denis Leahy, New Hampshire.  
 James Hugh McGinn, South Carolina.  
 Winston C. McKey, Georgia.  
 Samuel M. Neistadt, Massachusetts.  
 Daniel Eugene Van Nostrand, New Jersey.  
 Harold Edwin Reginald Pascoe, Australia.  
 Paul Lamar Pearson, North Carolina.  
 Hector L. Peloquin, Massachusetts.  
 Conrad Frederick Reiman, Connecticut.  
 David S. Robinson, New York.  
 Samuel A. Rosen, Maryland.  
 Charles Augustus Ross, Pennsylvania.  
 Jacob L. Solomon, New York.  
 Miss Lena C. S. Sparck.  
 Suel Vernon Strickler, Virginia.  
 Benjamin M. Thoman, Maryland.  
 James H. Tippett, New York.  
 Grover Cleveland Trumbo, West Virginia.  
 Ralph Edmund Tryon, New York.  
 Charles Edward Waters, Maryland.  
 Thomas Daugherty Webb, North Carolina.  
 William Pope Wilson, North Carolina.

**PRIZEMAN.**

University prize, gold medal, Paul Lamar Pearson.

*Honorable Mention.*

John Denis Leahy.

**DOCTOR OF PHARMACY.**

Hillard Adler, Maryland.  
 J. Dorsey Atkins, West Virginia.  
 Fitz James Bartlett, Maryland.  
 Carmen Benitez, Porto Rico.

Roy Murray Bierley, Maryland.  
 Henry Straughn Bramble, Maryland.  
 Clarence Newman Chavous, Georgia.  
 Nelson G. Diener, Virginia.  
 Edison Allen Fairey, South Carolina.  
 Walter H. Geffert, South Carolina.  
 Vann H. Gregory, Maryland.  
 Charles C. Habliston, Maryland.  
 William S. Harrison, Virginia.  
 Webster Blaine Jones, Maryland.  
 M. Ellsworth Kaufman, West Virginia.  
 Elmer R. Kellough, Maryland.  
 Katherine Korb, West Virginia.  
 Walter Lange, Germany.  
 Maria Francisco Mallen, San Domingo.  
 Kent White Scott, West Virginia.  
 Albert Soland, West Virginia.  
 Arthur G. Tracey, Maryland.  
 William Weltner, Maryland.  
 Waldo A. Werckshagen, Maryland.  
 Herbert H. Willke, Texas.

**PRIZEMAN.**

Gold medal for general excellence, Herbert H. Willke.

*Certificates of Honor in Order of Merit.*

Waldo A. Werckshagen,  
 Walter Lange,  
 Roy M. Bierley.

**SPECIAL PRIZES.**

Simon medal for superior work in analytical chemistry, Waldo A. Werckshagen.

Gold medal for superior work in practical pharmacy, Herbert H. Willke.

Alumni medal for superior work in vegetable histology, Walter Lange.

*Distinctions in the Junior Class.*

Gold medal for general excellence, Filberto Artigiani.

*Honorable Mention in Order of Merit.*

Clifford O. Miller,	Thomas E. Ragland,
Carville B. Boyd,	Paul F. Flynn,
Flora Blattstein,	

Honorary degrees were conferred upon Mr. William Reynolds of the Baltimore bar, who received the degree of master of arts, and Dr. Henry R. Carter of the United States Public Health and Marine Hospital Service, who received that of doctor of laws. It was the fiftieth anniversary of Mr. Reynolds' graduation from the University of Maryland defunct department of Arts and Sciences. He is a graduate in law of the William and Mary College, Virginia, and has practiced in this city since 1863. He is the author of several law books, and has also been active in politics,

having been secretary of the Reform League and the Civil Service Reform League.

Dr. Carter is a Virginian by birth, and was graduated in medicine from the university in 1879. He is stationed in Louisville, Ky.

Dr. Carter has been active as one of the surgeons of the United States Marine Hospital Service in the Gulf quarantine station since 1888, and also at the stations of the Panama Canal.

## MARRIAGES

Doctor Howard Kahn, class of 1900, was married to Miss Florence Ring, daughter of Mr. Lewis Ring of Baltimore, on Wednesday, June 8, 1910. Dr. Kahn was a house student of the University, and one of the honor men of his class. Since his graduation he has built up quite an extensive practice in Baltimore. For a number of years Dr. Kahn was an assistant in the histological laboratory of the University of Maryland.

Miss Cecelia Burch of Baltimore was married to Mr. Frank J. Bowlin of St. Paul, Minn., in Washington on Wednesday, June 8, 1910. The ceremony was performed by Rev. Dr. William Turner of the faculty of the Catholic University of America. Miss Burch was formerly a pupil in the University Training School for Nurses, but was obliged to discontinue the course, owing to an attack of typhoid fever. Her sister, Miss Emma Burch, is a graduate of the class of 1902.

Miss A. M. Phillips, a graduate of the University of Maryland Training School for Nurses, class of 1906, was married to Mr. F. J. Grenwell in Baltimore during the latter part of April.

Miss Katharine K. Landwehr, a graduate of the University Training School for Nurses, class of 1906, was married to Mr. Cassius McC. Lemley Wednesday, June 8, 1910.

Dr. Alex. R. Mackenzie, class of 1910, was married to Miss Una E. Cole of Los Angeles, Cal., in Ellicott City, Md., June 1, 1910. Dr. Mackenzie

is a native of Baltimore, and before entering the University of Maryland studied at the University of Virginia. He will practice in Charleston, W. Va.

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Dr. Robinette Burns Hayes, class of 1906, of Fayetteville, N. C., was married on June 1 to Miss Minnie Bond Anderson, a graduate of the University of Maryland Training School for Nurses, class of 1908, and daughter of Mr. and Mrs. E. M. Anderson of Mechanicsville, St. Mary's county, Maryland. The wedding took place at the home of Mr. and Mrs. William O. Tucker, 401 North Calhoun street, and the ceremony was performed by Rev. Peregrine Wroth, rector of the Church of the Messiah. Dr. Hayes was the gold medalist of the class of 1908, and during his senior year was an interne in the University Hospital. After graduation Dr. Hayes was assistant resident surgeon to the University Hospital. He then took up general practice in Baltimore, which he relinquished during the early part of 1910 to engage in hospital work in Fayetteville, N. C., where he, in connection with Dr. T. Marshall West, class of 1908, also an ex-assistant resident surgeon in the University Hospital, assumed the management of St. Luke's Hospital. Miss Anderson since her graduation has been engaged in private nursing in Baltimore. She was one of the most popular members of her class, whilst in training did excellent work and for the three years' course was the leader of her class. THE BULLETIN extends to Dr. and Mrs. Hayes its most hearty congratulations and best wishes.

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Dr. Arthur Louis Fehsenfeld, class of 1909, was married to Miss Viola M. Struven of Baltimore May 18, 1910. During his senior year Dr. Fehsenfeld was a house student. After graduation he accepted the position of resident physician in the insane department at Bayview Hospital. His term of office will expire June 15. He then intends to take up the practice of his profession in Forest Park, Md.

## DEATHS

Dr. John W. Hebb, Sr., class of 1860, died at his home near West Friendship, Md., May 18, 1910, aged 71 years.

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No. 5

## THE TREATMENT OF DIFFICULT FRACTURES.

By R. P. Bay, M.D.,

Superintendent University Hospital, Baltimore.

In considering this ever-important subject of difficult fractures I wish to consider that class in which, by virtue of some abnormal anatomical change of the parts, we are unable to properly reduce the fracture or to keep it in place after it has been reduced by simple non-operative treatment.

In order to obtain the union of fractures all practitioners have taken account of one fact alone, that a bone is a rigid lever. When broken, the fragments must be fixed in the position of a normal bone and immobilized. To reduce and immobilize are the only measures upon which attention is riveted.

Operations for the treatment of fractures have been practiced for a long time, but mostly resorted to for the correction of an ununited fracture or for faulty union; but it is only in later years that attention has been given to the open treatment of recent difficult fractures, owing doubtless to the dangers of infection and to the absence of the X-ray in making the correct diagnosis.

Mr. Lane, of London, in his extensive investigations of fractures, calls attention to the large number of men whose wage-earning capacity has been lessened by the faulty union of broken bones.

Learning by experience that a large number of these cannot be corrected by non-operative measures, it seems reasonable that more attention should be given to the operative procedure, without, of course, going too far in this direction.

The result in fractures is not only of importance to the patient, but is also of moment to the physician, as his reputation may easily be ruined by a bad result, and especially is this true since the ad-

vent of the X-ray. A cripple in a community is an advertisement of a doctor's mistake, and is a constant embarrassment, to say nothing of the medico-legal aspect.

In this age of advanced scientific methods no one should be content without the aid of the X-ray, and there should be no excuse for not recognizing a faulty position. No case, wherever possible,



FIG. II.—AFTER THREE UNSUCCESSFUL ATTEMPTS TO REDUCE. SIDE VIEW.

should be let go without this valued aid. We may say that it is not invariably necessary or desirable to replace bones exactly as they were before they were broken, but it is always better for the surgeon to recognize the situation and explain it properly to the patient than for the latter to find it out for himself in the future.

The difficulties arising in the reduction of frac-



FIG. IV.—PHOTO SHOWING FOREARM AFTER OPERATION. LATERAL VIEW.

tures by the simple non-operative means of treatment are:

- (a) Interlocking of fragments.
- (b) Interposition of bones or soft parts.
- (c) Fixation of one fragment in the fascia or in the skin.
- (d) A dislocation complicating a fracture.
- (e) Impaction of fragments.

These obstacles may best be overcome by an early effort, which, if the patient's condition permits, should be immediately following the injury. The administration of an anesthetic is of the utmost importance in all fractures, especially those in close proximity to the attachment of large muscles, whose contractions tend to displace and keep displaced the fragments.

I do not wish to encourage the open operation for all fractures, any more than I would a craniotomy for all headaches. As—

- (1) No recent fracture should be operated upon that can be successfully treated by other means.
- (2) No simple fracture should be operated on, except under the most favorable surroundings, and by an experienced surgeon who is a master of aseptic technique.
- (3) The indications for operation vary greatly

with the particular bone which is broken, the character of the break and its situation in the bone. For instance, all compound comminuted fractures should, when possible, be treated by open operation. The fracture of both bones of the forearm or leg usually require open operation to insure good results. Fractures of the epiphysis demands the greatest necessity for operation, because of their interference with the joint function from the ends of the broken bones, from loose fragments or from excessive callus. It will seldom be necessary to operate on transverse fractures in the shaft of long bones. When an operation is necessary upon a diaphysis it is generally because of an oblique or spiral fracture, where extension is most apt to fail or because of a portion of muscle between the fragments.

#### OPERATIVE TECHNIQUE.

Every precaution must be taken to avoid infection, which is an ever-present and serious danger. In no other wound have we so susceptible a field for infection. I do not believe in strong antisepsics in these conditions, but adhere more closely to perfect asepsis. The field should be thoroughly cleansed with green soap and water, after careful shaving, following this with alcohol and ether, and

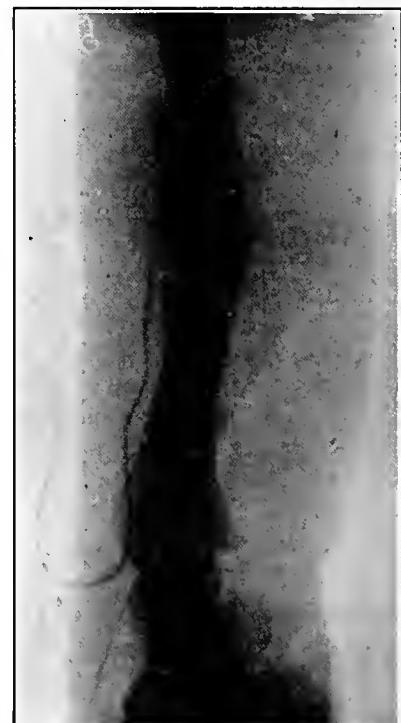


FIG. IV.—FOLLOWING OPEN OPERATION. RADIUS WIRED.



FIG. V.—PHOTO SHOWING FOREARM SIX WEEKS AFTER OPERATION. FRONT VIEW.

finally with normal salt solution. I consider that sponging during the entire operation with hot salt sponges is of considerable advantage; it lessens oozing and cleanses the parts. In making the incision the fracture should be approached from an aspect which necessitates a minimizing damage to the soft parts, and freely, as plenty of room is always necessary. All blood clot must be removed and the bleeding controlled. The reduction, after the fragments are exposed, will often call for extension and counter-extension, as well as direct manipulation.

In most difficult fractures it will be necessary to fasten the fragments together in some way, but when this can be avoided with security by fitting the jagged ends into each other it should always be done, as a foreign body adds to the danger of sepsis and delayed union. Of the materials we have at our command the most universally employed are: Bronze-aluminum wire, silver wire, iron wire, plates, screws, staples, clamps and nails. Of these, they may all have their field in selected cases. Silver wire breaks easily, and has been discarded by many, but in the majority of cases, properly applied, it will be the material of choice. Screws are especially adaptable in oblique fracture of the femur and in fractures of the neck of the humerus

and femur. Plates are useful in transverse fractures of long bones, but are large, and the larger the foreign body the more liable we are to have necrosis and suppuration. For this reason I believe the complicated clamps devised by different surgeons have only a limited field.

Unless there is reason to anticipate infection, as in compound or badly comminuted fractures, the wire or screw should be buried without provision for subsequent removal. In compound fractures a drain, preferably gauze, should be instituted, which, if no evidence of infection is present, should be removed in 48 hours and left out, the wound healing by first intention.

Figure 6 shows a compound comminuted fracture, with dirt ground into the wound, drainage removed in 48 hours after operation, wound healed by first intention, patient walking in 12 weeks.

I prefer the silver wire subcutaneous suture for the skin. Bones must be held in place by properly fitted splints or plaster casts, fenestrated to enable inspection of wound from time to time. At the end of six weeks, under favorable conditions, the



FIG. VI.—COMPOUND COMMINUTED FRACTURE OF TIBIA AND FIBULA FOLLOWING CRUSHING INJURY.



FIG. VII.—COMPOUND COMMUNICATED FRACTURE WIRED. GOOD UNION AND WALKING TEN WEEKS AFTER INJURY.

bones will have become firmly united and passive motion may be instituted.

Fig. 2 represents fractures of both bones by direct violence, and shows the result after three unsuccessful attempts at reduction under anesthesia.

Figs. 4 and 5 show the result six weeks after operation.

Fig. 6 represents a compound comminuted fracture of tibia and fibula.

Fig. 7 shows fracture after operation and fragments held in place by wire suture. This patient was able to walk without crutches 12 weeks after operation, with no limp or deformity.

Dr. John G. Selby, class of 1899, was elected vice-president of the new medical society, the Clinical Society of the North Atlantic Medical College, which was founded at a meeting held in the amphitheater of Franklin Square Hospital July 12, 1910. Among the charter members are Drs. Wilbur F. Stubbs, class of 1902; William S. Love, class of 1890; Albert T. Chambers, class of 1898; Irvin Ebaugh, class of 1880; E. Miller Reid, class of 1864, and Howard D. Lewis, class of 1900.

## SUPPURATIVE CONDITIONS OF THE MIDDLE EAR DEMANDING SURGICAL INTERFERENCE.

By WILLIAM TARUN, M.D.,\*

*Chief of Clinic, Eye and Ear Department, University of Maryland.*

I must ask you to permit me to limit my paper to the acute suppuration of the middle ear demanding surgical interference, as the time at our disposal is insufficient to consider the chronic conditions which frequently require surgical treatment.

I shall ask your pardon also for bringing this subject to your attention. I do so, however, at the request of your president, and with the distinct understanding that I am not to consume more than my allotted time.

It will perhaps be wise to have a few words to say concerning the anatomy of the middle ear and mastoid process. This would make it less difficult for you to understand why certain symptoms are more conspicuous in the young and others more in the adult.

The middle ear, as most of you know, is merely a box surrounded on all sides by bone except the external boundary or drum membrane. This box is in communication with the naso-pharynx by a tube, the Eustachian tube, with the antrum or constant cavity in the mastoid by the aditus.

The ease with which this part of the ear becomes infected and complications occur depends upon the width of the Eustachian tube and the size of the opening extending into the mastoid cavity; also upon the not infrequent presence in the roof of the middle ear of a fissure or imperfectly developed internal cortex whereby a collection of pus in the tympanic cavity is easily forced into the cranial cavity with a resultant serious brain complication.

There are marked differences in the temporal bone of the infant and the adult. In the former the bone is undeveloped, there is a relatively wider Eustachian tube, and this wide tube, coupled with the frequent lymphatic disturbances to which infants are subject, plus the inability to free the nose and naso-pharynx of the collection of mucus, makes it an important factor in the production of a middle-ear inflammation. This mucus is easily

\*Read before the Anne Arundel County Medical Society June 18, 1910.

forced into the wide tube and middle ear in the act of coughing and sneezing.

Again, the antrum, which, as I have said, is a constant cavity in all mastoids, is relatively larger in infants than adults; it has also a larger opening from the middle ear into it, and therefore makes children more susceptible to a mastoiditis than adults. Mastoiditis is found in children in about 70 per cent. of cases.

One other point to which I would like to call your attention is the extremely thin external cortex of the mastoid in children, whereas in adults it is usually so thick that one is easily thrown off his guard should he wait for external symptoms to appear before a positive diagnosis is made. I shall mention a case in point later.

An acute suppuration of the middle ear is due to an infection. Pus may or may not be visible in the canal. The three cardinal symptoms are pain, increased temperature and a rapid pulse. One or all these symptoms are unmistakably present. I shall confine my remarks to the symptoms other than the appearance of the drum membrane, as most of you are dependent upon these for aid in the diagnosis. Other symptoms are not infrequently observed, and which demand attention. These I shall also speak of.

The patient, if an infant, has or had an exanthematous disease, a bronchopneumonia, a disease of the intestinal tract or a rhinitis. It may or may not appear to be in pain. Certain it is that if during its sickness or in its convalescence there should be a rise in temperature, rapid pulse or convulsions for which no explanation can be given, the attending physician is neglectful of his duty if he does not make or have made an examination of the ear. I wish further to emphasize this as applying to adults who are extremely sick from pneumonia or typhoid.

Because of the absence of pain in the ear one is apt to believe a relapse has occurred, and not until the membrane has ruptured and pus appears in the external canal is he aware of the true condition. This absence of pain is an indication of a marked systemic toxemia. Severe pain is usually found in acute cases as a result of an infection from the nose, nasopharynx or tonsils. Here the pain is excruciating, and when associated with a partial or complete deafness, not present before the onset, it means that your patient has a condition in the ear demanding surgical interference.

It might be well here to give a few points on the differential diagnosis between infection of the

canal, middle ear and reflex otalgia. If pain is present and due to a middle-ear disease, there is defective hearing which had not previously existed.

If it is present without defective hearing and the pain is increased on manipulation of the auricle, it is due to an infection of the external canal and will probably subside by the use of hot applications or incision of the furuncle. Abscesses of the canal are always located on the cartilaginous part, and any movement of this cartilage causes extreme pain.

If no defective hearing is present, and no pain on motion of the auricle, it is probably a reflex condition, and the cause can most likely be found in the teeth or tonsils.

The temperature in most middle-ear suppurations varies a great deal. In children it may reach as high as 106, and in adults may be as low as 101. If, however, a complication of the meninges is present it may be extremely high, remaining there most of the time, whereas in an involvement of the brain tissue or brain abscess it is usually below normal.

The pulse varies also from normal to as much as 160. As a general rule, pulse rate and temperature are higher in children than in adults.

Generally in all suppurative conditions of the middle ear one finds an amount of tenderness on pressure over the mastoid, which, when persistent, is almost sure to demand an incision of the drum membrane. This mastoid pain is not an absolute indication that the mastoid is already infected. In all acute suppurations of the middle ear there is a corresponding hyperemia or inflammation of the mucosa of the mastoid cells, pus may even be present, but this pus is sterile, and not until an infection has been implanted has one sufficient cause to open this cavity. After an incision has been made in the drum membrane and the pus evacuated there is a subsidence of this tenderness within a week or 10 days. A persistence of this tenderness after the evacuation of the pus, either spontaneously or by operative measures, and a gradually increasing severity, generally means a complication of the mastoid structure.

I should like to impress upon you also the fact that when edema and fluctuation are present over the mastoid area, particularly with a discharge of pus from the canal, a positive diagnosis of mastoiditis can be made. There is hardly a possibility of this subsiding by evacuating the pus from the middle ear alone.

After pus has appeared in the external canal it is not difficult to make a diagnosis of a suppuration of the middle ear, and generally by some method of cleanliness the patient gets well, with more or less defect in the hearing as a result.

Still, in spite of all the cleanliness and faithful attention, some pain and discharge continue. Either the perforation is so small and the discharge so tenacious because of its mucoid character that it cannot escape well, or the perforation is so high that there is always a large amount of pus left in the ear below the level of the perforation and cleanliness is imperfect. This becomes stagnant and undergoes putrefactive changes, with all its evil consequences. In these conditions it is necessary to still further enlarge the opening, so that it is on a plane with the floor of the middle ear, a position in which drainage takes place most effectively.

It might be asked, "What effect has a spontaneous perforation or one made surgically" on the hearing of the patient? It is found there is still the general impression among physicians as well as laymen that a perforation in the drum means deafness. Fortunately, this impression is not founded upon facts. On the contrary, fairly good hearing is by no means inconsistent with practical destruction of the membrane. Nevertheless, no matter what the effect on the hearing, it is of the utmost importance in an infected middle ear to evacuate the pus preferably by incision rather than permit it to rupture spontaneously.

Persistent discharge may be due to several other factors. When it is of a mucoid character it is undoubtedly due to an interference with proper drainage through the Eustachian tube as a result of enlarged tonsils or adenoids, and not until these have been removed is one apt to have a cessation of the discharge.

Where, however, the pus is creamy in consistency, and very profuse and persisting, in spite of all the cleanliness, it is safe to assume that this large quantity is coming from the mastoid cavity.

As an instance of this I wish to cite a case recently in my care. Dr. X., aged 56, residence North Carolina, had an attack of grippe about two months prior to consulting me. A few days after its onset he complained of severe pain in the right ear, followed in 36 hours by a serous discharge from the canal. This a few days later changed its character to a purulent one, and has since con-

tinued to discharge profusely. He had seen several physicians in his State, and was told he had merely a middle-ear suppuration, which would soon get well. Finding a need of bringing a patient to this city, he came into my care at the suggestion of Dr. Bay. On examination it was found he had no pain or tenderness over the mastoid region, no pain in the ear, no edema. Temperature and pulse normal. The discharge from the middle ear was very profuse, and of a creamy consistency. There was present in the canal also a small polypus. His leucocyte count was 17,000. A relative count was not made. The removal of the polypus and irrigation for a week caused the leucocyte count to fall to about 9000, or normal. The discharge, however, remained very free; its character had not changed for several weeks; so in spite of the fact of the temperature, pulse and blood count being normal, and no external symptoms of edema, or pain or tenderness, he was advised to have his mastoid opened. He was somewhat reluctant about having it done, but after some persuasion and impressing upon him the importance of the probability of an exposure of the meninges and lateral sinus, he submitted to an operation. The external plate was about one-half inch thick. After chiseling through this there was immediately a flow of pus under pressure and pulsating. Upon further opening of the cavity there was found an exposure of the dura and sinus for about one and one-half inches in the vertical plane and one-half inch in the horizontal, with a large quantity of granulation tissue over the sinus. The mastoid cavity and antrum were cleaned out thoroughly and packed with gauze. He was dismissed in about six weeks cured.

This is a striking example of the danger of waiting for external symptoms of mastoiditis to appear in an adult. In this instance the external plate was so thick that it became impossible to perforate and present symptoms of swelling behind the ear. Fortunately for the patient, drainage was taking place by way of the external canal.

Can any temporary measures be instituted to relieve your patient of pain resulting from an acute infection of the middle ear? Not only can the pain be partially or entirely relieved, but it is also possible to abort a suppuration. Should, though, the pain persist after 48 hours, in spite of the local measures used, I should strongly advise a wide incision of the drum membrane in the primary

stage of general anesthesia, and the middle ear drained.

As the proper measures for earache, when the diagnosis has been made, I would suggest a free purge to be given, so as to deplete the blood vessels as much as possible. The administration of sodium salicylate every three hours and the instillation into the canal of 10 to 15 drops of the following: Carbolic acid, c. p. 40 drops; alcohol, 1 dram; glycerin, q. s. 1 oz. This to be used every three hours and hot compresses applied over the ear.

Carbolic acid is an anesthetic, the alcohol prevents its burning action and the glycerin is a dehydrant. Repeated as frequently as stated, it is usually quite effective.

Should, however, the pain in the ear or over the mastoid increase in spite of these measures, an incision of the drum membrane is unquestionably called for.

I have purposely refrained from saying anything about the appearance of the drum membrane in acute suppurations of the middle ear, because of the marked changes taking place in its topography—changes which, even to an experienced aurist, are sometimes most puzzling.

I have tried to point out to you the symptoms of importance by which you can determine the need of some surgical measure. I hope I have succeeded in doing this.

In conclusion, I wish to suggest a few maxims to bear in mind:

1. If symptoms are not relieved by internal and local remedies within 48 hours, make a free incision in the drum membrane.

2. Children are especially prone to middle-ear infections, because of the relatively wide Eustachian tube.

3. In convulsions in children, plus temperature and increased pulse rate, look for the causative factor in the middle ear.

4. External evidences, as tenderness, edema and fluctuation over the mastoid area in children, are not infrequent, but by no means necessary.

5. External evidences, as tenderness, edema and fluctuation over the mastoid area in adults are conspicuously absent.

6. Middle-ear infection in extremely sick patients or those convalescing is not characterized by pain in the ear or mastoid, but by an unaccounted for rise in the temperature.

## WHAT CAUSES HYPERTHYROIDISM?

By WIRT M. DUVALL, M.D.

Goitre, from "Guttur," meaning throat, an enlarged thyroid gland. The importance of this very interesting part of the human economy is being slowly recognized. Observation shows two glands partly connected by a band, or isthmus, and Gray says this is sometimes absent.

The situation of this organ is in the neck, opposite the second and third ring of the trachea; a lobe on either side thus embracing anteriorly the larynx. In general appearance it is very like other glands of the body, except it has no excretory duct, giving it, along with a few others, the general classification of "ductless gland."

The thyroid consists of a collection of vesicles connected into lobules by areolar tissue. The fluid of the vesicle is yellowish, and holds in suspension dotted cells. The chemical reaction of this fluid is very like egg albumen. The gland weighs about two ounces, being slightly larger in the female than in the male. The cell is lined with cuboidal epithelium, the fluid of which, known as colloid, is to the best tests chemically an iodized albumen.

In the development of the body the function of the thyroid gland is noticed from a clearer viewpoint, since the absent gland child quickly shows the need of same, both mentally and in body formation. If for reasons the removal of the thyroid is necessary, care must be taken to remove not one bit more of this gland than is positively required, since a miserable condition follows this operation, known as myxedema. This leads us to a study of the unduly enlarged gland, since not all enlarged glands are a menace to life and comfort.

The first step in the study is the blood supply; this is from the superior and inferior thyroid arteries. The superior thyroid is from the external carotid and of unusual size and shape. And yet, notwithstanding its large blood supply, a great portion of it may be cut off and the gland not suffer very greatly. The thyroid gland is subject to other degeneration, but let us confine our thoughts to that form of enlargement that calls for active treatment. That condition known as Graves' disease, or exophthalmic goitre, which is said to be a constitutional disease due to excessive secretion

and absorption from an over-acting thyroid gland. Accepting this as the best theory, thought now centers on the cause of this condition. We are now face to face with the function of the gland. In this speculative field one is led to think of the parathyroids as check organs on the larger glands, as well as having other functions. By some it is held that medical treatment is of no value, the knife being the only remedy. With this idea I differ, on theory and experience. That there are cases requiring surgical aid no sane mind should deny, but those are cases either neglected or overlooked in the earlier stages, which, if properly treated, might have yielded to medical attention. While my experience is very limited, I have treated what was thought to be hyperthyroidism with the parathyroid glands in medicinal form, and the result was marked in two cases. Thought is directed not to Graves' disease or exophthalmic goitre developed, but back, and beyond this, that which causes this dangerous and very unsightly malady.

As to surgical aid, the operation has under skillful men been done many times with varying degrees of attainment.

The operation is not infrequently followed by grave complications, great care being necessary not to injure the recurrent laryngeal nerve or to remove the parathyroid, and last, but not least, the entire removal of the thyroid gland, as before mentioned, leads to that complication known as myxedema. I have never seen such a result, and give this as the observation of others.

Removal of the parathyroids in animals is followed by tetany, with partial paralysis of the extensors, a sudden rise of temperature and death in about 48 hours. McCallum and Voegtlind claim to find a loss in calcium phosphate in blood and muscle after tetany death. Silvestri suggests that eclampsia could be explained by a diminution of calcium in the organism.

Some observers claim to get good results from salts of calcium in tetany. My own experience is valueless, having treated but one case of tetany, which I reported in the *Maryland Medical Journal*.

It is but reasonable to suppose that after removal of the parathyroids a toxin of some sort is absorbed, and it is as reasonable to think of the product of the parathyroids as an antitoxin. But what of the thyroid gland? Is the toxin produced here?

To the student mind the field of organotherapy offers pleasures beyond description; it is the hidden secret of the human physiology, and until these almost unknown parts are fully explored the doctor is deprived of that knowledge that leads to exact conclusion. It was as late as 1880 that the parathyroids were discovered by Sandstroem, and today their function is more or less of an enigma, views of many being wide and different. While not assuming a rôle beyond my sphere, I am led from a limited knowledge to reason that a part of their function is to act as a check upon the thyroid glands. The parathyroids, generally four in number, are situated just behind the posterior margins of the thyroid. They are about the size and shape of a small grain of corn, of a reddish-brown color and are in close relation with the inferior thyroid artery, from which they receive their blood supply.

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The engagement has been announced of Dr. Emile Boniwell Quillen, class of 1904, of Wilmington, N. C., to Miss Leila Griffith Owings of West River, Md. Dr. Quillen was a good student, and was one of the most popular members of his class. After graduation he served one year as resident pathologist to the University Hospital, and was then appointed superintendent of the Rocky Mountain Hospital of the Atlantic Coast Line Railroad, and a few years since was promoted to the position of assistant superintendent to the Atlantic Coast Line Relief Department, of which Dr. George Gillett Thomas, class of 1871, is superintendent and chief surgeon. Miss Owings is a graduate of the Training School for Nurses, class of 1905. She is the daughter of Mr. and Mrs. U. G. Owings of West River, Md. Since graduation she has been engaged in private and institutional nursing, her most recent position having been that of superintendent of St. Luke's Hospital, Fayetteville, N. C., of which Drs. R. B. Hayes, class of 1906, and Marshall T. West, class of 1908, are the proprietors.

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Dr. Norman Dudley, class of 1901, appointed by the Queen Anne's County Medical Society to look after the interests of the medical fraternity at the recent session of the Legislature, made his report at the meeting of May 19.

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Dr. S. Demarco is building a cottage at Rehoboth, Del.

ADDRESS TO GRADUATING CLASS OF  
St. JOSEPH'S HOSPITAL TRAIN-  
ING SCHOOL FOR NURSES, HOT  
SPRINGS, ARKANSAS.

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By W. TURNER WOOTEN, M.D.  
(Class of 1899.)

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*Mr. President, Gentlemen of the Faculty, Ladies of the Graduating Class; Ladies and Gentlemen:*

At the commencement of your careers as nurses it becomes necessary to have some one advise you as to how you may best succeed—just as it is necessary for the young mother to be advised by the old maid how to raise her baby.

I offer no apology for being here in an advisory capacity—the fault lies entirely with your Honorable Board of Governors. My sole instructions from the president are to say nothing in as short a time as possible.

Heretofore, in addressing you when I didn't know what to say I could quiz, but tonight that privilege is denied me.

It is with a great deal of pleasure that I point out to you the fact that you must reach a very exalted proficiency in your profession in order that you may not lower the standard already set by preceding classes.

Never has it been my pleasure to meet one more capable of instilling the love, the ideals and practice of your chosen work than your very efficient superintendent.

That she has not labored in vain is daily demonstrated by the glorious work of the graduates of this school—of whom, I say—none are superior—few are equal.

In pondering the lives of these young ladies to whom success is assured, it seems to me the keynote of their ascendancy is love of chosen work. 'Tis so in all professions—in all walks of life.

Choose any one of these eminently successful men sitting here and have him spend a month in rest and recuperation away from his work. The latter two weeks of that month will be spent in anxiety and restless longing to get back to his office. Why? Consecration and love of chosen work. It has now become so much a part of his life that there can be no substitute.

If you are not thoroughly in accord with your

daily duties you are going to neglect the smaller things—the things that go to make up a good nurse, the nurse who loves to do the things of the now—not of the morrow.

It is she of the infinite patience, tenderness and concern for the suffering of others—God's less fortunate creatures—who is the true nurse; others are attendants. Don't be an attendant.

Skill alone will not compensate for lack of thorough sympathy for all you see and do; your diploma does not make you a nurse; that quality lies within you and is for you to develop to that rich fullness we all contemplate when we think of the trained nurse.

Develop your power of love—love for your work and not too much for your patient. Statistics show conclusively that as love for the patient grows, love for work wanes until it is all patient and no work.

How different with the doctor. When the nurse marries she stops her work. When the doctor marries, he can't.

Put your whole will, love and determination in whatever you do, and success is assured.

I thank you for your endurance and indulgence.

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Dr. John R. Winslow, class of 1888, and Mrs. Winslow will sail July 16 on the Hamburg-American liner Cincinnati for Germany, and will spend several weeks touring Germany and Holland, returning to Baltimore in the fall.

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Dr. William T. Vance, class of 1881, of Berwick, Pa., is president of the Columbia County (Pennsylvania) Medical Society. The Society is composed of 40 members. Dr. Vance has been very successful as a general practitioner.

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The County Commissioners of Baltimore county have appointed Dr. J. Marshall B. West, class of 1901, as health officer of the first district, to take the place of Dr. Arthur H. Mann, class of 1890, who resigned because of ill-health. In 1901-1902 Dr. West served as assistant resident physician, in 1902-1903 as assistant superintendent and assistant resident gynecologist in the University Hospital. Since leaving the hospital he has engaged in private practice in Catonsville, Md., where he has built up a large practice.

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, MD., JULY 15, 1910.

## REPORT OF THE CARNEGIE FOUNDATION FOR THE ADVANCEMENT OF TEACHING.

*Bulletin No. 4. Medical Education in the United States and Canada.*

The above-mentioned report appeared early in June of this year, and was given the widest publicity in the medical and lay press. The report is written by Abraham Flexner, an A.B. of the Johns Hopkins University, and a brother of the more distinguished Simon Flexner, now the Director of the Rockefeller Institute for Medical Research. Mr. Flexner claims to have visited and carefully inspected every medical college in the United States and Canada. He is not a medical man, and consequently can hardly be expected to be a good judge of what is and ought to be a good medical school. He is also an employe of an institution founded by a man whose money was made by "trust" methods, and it is perhaps natural that the officials and employes of the Carnegie Foundation should also be saturated with the "trust" idea. Whilst many of his statements are erroneous, and some of them absolutely untrue, and whilst a spirit of conceit of herculean proportions pervades the report, it is nevertheless a document of great importance and interest, and one that will have a marked influence upon medical education in this country. The report is not constructive, but destructive, in its tenor, and is entirely devoted to the interests of the endowed medical schools connected with the large universities, whilst those that are less favored with filthy, and

perhaps tainted, lucre are invited to get off the earth.

The good effect of Mr. Flexner's highly egotistical report is most found in the detailed account of the financial resources and educational capabilities of the various schools of the United States and Canada. It is more than probable that many errors have found their way into this report, but if the statistics given are true, nearly one-half of the medical schools of this country have incomes of less than \$10,000 annually, which is manifestly an insufficient sum for the maintenance of any school. Also a large proportion of the schools are woefully lacking in both laboratory and hospital facilities, and many of them are small in size and are situated in unfavorable locations. There is therefore no doubt that at least one-half of the existing schools could easily and advantageously be dispensed with. As has been said, the report is not constructive, but destructive, and only a few schools have met with the approbation of our censor. Mr. Flexner's attitude is a most offensive one. He assumes that most medical teachers are insincere and are actuated only by sordid motives, and that their statements can only be relied on to the extent of being considered untrue. Mr. Flexner sets up an ideal which the "proprietary" schools, as he delights to call all those which are not the fortunate possessors of an ample endowment, not being able to attain, must close up and go out of existence. This ideal is the Johns Hopkins Medical School. We are all willing to concede the excellence of this famous institution, but it is by no means certain that the Hopkins methods are the best, or that it would be advantageous for many schools to follow its example. We believe the Hopkins to have a unique position in the field of medical teaching, but it is by no means proven that it would be best, even if it were possible, for their standard to be adopted by most of the other colleges.

Mr. Flexner does not much believe in the "poor-boy" plea, and his attitude toward the poor boy is very much like that of the late Mr. Vanderbilt toward the public. In other words, medical education is to be an aristocracy rather than a democracy. As was to be expected, this report has been met with furious protests from many of the attacked medical schools, and the St. Louis College of Physicians and Surgeons has already entered suit for \$100,000 against the Carnegie Foundation, Henry S. Pritchett, its president, and Abra-

ham Flexner, the author of the report. Mr. Pritchett, in his introduction to the report, says: "The attitude of the Foundation is that all colleges and universities, whether supported by taxation or by private endowment, are in truth public-service corporations, and that the public is entitled to know the facts concerning their administration and development, whether those facts pertain to the financial or to the educational side." It is interesting in this connection to note that the Attorney-General of Maryland controverts this opinion, and says: "These colleges are not public-service corporations," and further, "a college, while its work is of high interest and moment to the public, is nevertheless a private and eleemosynary corporation." If this is true, there is a very strong doubt whether information obtained under specious pretense can be given the widest publicity, to the absolute detriment of certain institutions, without the Carnegie Foundation being liable for damages.

Let us now consider the report as it concerns the University of Maryland. In fact, there is but little said that is not favorable, even though the animus of the author is entirely inimical. Some of his statements are true, some are foolish, and some are absolutely false. He seems to have a special animosity to our University, notwithstanding the fact that his brother, Simon Flexner, was very glad to receive the LL.D. degree from us in 1907. He says: "A harmful precedent was established in Baltimore with the foundation of a 'proprietary school' early in the nineteenth century—the 'so-called medical department of the so-called University of Maryland.'" This statement is absurd; we are certainly the medical department of something, and this something happens to be the University of Maryland. According to Flexner, a university charter does not make a university, a proposition we are entirely willing to subscribe to, but we are not willing to accept a statement made by him in a letter to our dean that the State cannot create a university, which, by inference, can only be done by Messrs. Pritchett and Flexner. Neither do we accept the postulate that a university must originate in a school of liberal arts. Apparently Flexner, A.B., does not know that his own beloved Hopkins started as a graduate school, and not as a school of arts. We are willing to let him entertain his own opinion as to whether we are a university or a proprietary school, but we absolutely deny that we are nomi-

nally the medical department of St. John's College, Annapolis, a statement gravely made, though denied by us in ample time for correction. We do not know what constitutes a four-year high-school requirement in Flexner's opinion, but our entrance conditions are those of the Association of the American Medical Colleges, which we live up to as far as we know how. We do not admit any students, except those who have undoubted college or high-school diplomas; those about whom there is any doubt are sent to the authorized examiner for his rating or examination. Even in the matter of income we are incorrectly quoted, as the amount credited to us is said to be "estimated," whilst, as a matter of fact, the items were stated in detail, as in a balance sheet. He says we are a large commercial enterprise, and that education is overshadowed by business. It might be proper to use a strong expression in regard to this statement, but we will content ourselves by simply denying the allegation. It is quite true, as he says, that we have not sufficient income, and we are trying strenuously to secure an adequate endowment, but, according to Flexner's own tables, there are but 24 medical colleges in the United States and Canada that have more income than we. In point of attendance there are but 18 schools, including one osteopathic institution, that have as large classes as ours. "Good undergraduate laboratories, adequate for routine teaching, are provided." This is pretty high commendation. We do not profess to be an institution for post-graduate instruction, though we have quite a few post-graduate students doing work in our hospital and laboratories, which they find satisfactory for their needs. Mr. Flexner says, "Anatomy is poor." We do not think he is competent to judge. We have an excellent anatomical laboratory, with an abundance of material and a full corps of competent and faithful teachers. Students are carefully instructed in class sections in osteology and syndesmology, and each student is supplied, gratis, with a complete set of bones to use at his home. The didactic instruction under the professor of anatomy is full, exhaustive and lucid. We take the liberty of differing with Mr. Flexner in regard to the teaching of anatomy in the University of Maryland; we believe it is exceptionally good. We may not lay much stress on the lymph spaces in the tail of the cat, but the anatomy of the human body is thoroughly taught, and that is the important matter for those who are to practice medi-

cine and surgery on human beings. We do, however, sympathize with his gentle plaint that, notwithstanding the proximity of the University of Maryland to the Johns Hopkins, it has profited nothing by the opportunities to modernize the teaching of anatomy. Isn't it a shame? It is surprising how few medical schools own or control a hospital. We are kindly credited with the ownership of an excellent hospital of 140 beds. As a matter of fact, the capacity of the University Hospital is normally about 210 beds, and can be augmented in emergencies to about 240. Our obstetric clinic is said to be ample; during the past year over 1000 deliveries occurred in the obstetric wards and out-service department. "The dispensary is large, properly equipped and well kept." From 25,000 to 30,000 visits are made by patients to the dispensary yearly, and are used for clinical teaching. Flexner disapproves of the bounty of the State being given to the independent medical schools, and says it should be bestowed on the Johns Hopkins alone. He is in error in saying that neither the city nor the State has ever done anything for the Johns Hopkins Medical School. The State for a number of years has appropriated annually \$25,000 to the Johns Hopkins University, and after the great fire, in 1904, appropriated a lump sum of \$50,000 to the Johns Hopkins Hospital to recoup it, in a measure, for its losses by the fire. In conclusion, he invites the University of Maryland and the College of Physicians and Surgeons to close up and turn over their assets to the Johns Hopkins. With a naiveté quite refreshing, he says: "To their present hospitals the Johns Hopkins would become the heir, thus greatly strengthening its clinical resources." We wonder when he thinks this delectable state of affairs is likely to come to pass! The University of Maryland Medical School has been in uninterrupted and successful operation for 103 years, and we strongly suspect that it will still be fulfilling a useful and beneficent mission long years after the gentle Flexner shall have been carried into Father Abraham's bosom.

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HAS THE UNIVERSITY OF MARYLAND  
ANY CLAIMS TO THE DIVINE  
RIGHT OF EXISTENCE?

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The word has been passed that it is high time for the University of Maryland to close up shop and turn over its assets to the Johns Hopkins

University. A so-called educator of the country—Flexner by name—is the author of the above proposition. Coming from such a source the proposition is extremely insulting in character. It is not entirely to subserve the ends of education, either, for this Flexner is a graduate of the undergraduate department of the Johns Hopkins University, and takes it as a dire piece of impudence that the University of Maryland dares compete with the Johns Hopkins University. He is the representative of an educational oligarchy, and the existence of a poor institution doing good work is a beam in his eyes. It goes without saying that the vituperative rantings and slush of a three-ball artist will fail utterly in wiping the University from the face of the educational world.

But what retort have we to make to this executioner of schools? Have we any claims to existence? According to Mr. Marbury, the chief claim, and if no others existed, a sufficient one, is our antiquity. Any institution in this country which has weathered the stress and storms of a hundred years is ancient, and as such should command the love, respect, veneration and support not only of its alumni, but also of the citizens of the State in which it is located. According to Marbury, this nation is composed of two countries—that embraced by the original 13 States (with a legend of traditions), and the West, a new country (with new ideals, with nothing of antiquity to bow their heads to, with no hard and fast customs).

Institutions founded a hundred years ago were the product of men of Anglo-Saxon blood, tradition and mode of thought, men similar in character to those who created the new nation, men some of whom fought and bled for the privilege of having a say concerning the form of government under which they should live. It was these men, or just such men, who formed and have handed down to us the University of Maryland, one of the few institutions founded during the early days of the Republic. Surely for this reason alone the University of Maryland, which has lived a continuous existence, and has never closed its doors to the youth of the land, even maintaining classes during the dark days of the Civil War, should not be denied the privilege of existence. Such a proposition should arouse our citizens to arise in their might and declare the man who broached such a course a Judas.

## DR. LEWIS M. ALLEN.

With much regret we announce that Dr. Lewis Mines Allen, class of 1896, associate professor of obstetrics in the University of Maryland, has severed his connection with the institution, in order to engage in general practice in Winchester, Va., where he will assume the practice of the late Dr. Samuel Peachy Latane. Since his graduation Dr. Allen has been associated with the obstetrical department of his alma mater, where he has rendered invaluable services as a teacher in his specialty. His loss is incalculable, Dr. Allen possessing to an extraordinary degree the faculty of imparting knowledge to students. His personality is exceedingly pleasing, and his grasp of his subject deep. He is exceedingly popular with graduates and students alike. Our loss of his services is irreparable.

Dr. Allen, a native of Virginia, but since his graduation in medicine a citizen of Baltimore, was born in Berryville, Clarke county, Va., August 11, 1874. He is a son of Robert Owen and Edith Howard Allen. His earlier education was obtained from private tutors and at Shenandoah University School. He was educated in medicine at the University of Virginia and the medical department of the University of Maryland, receiving from the latter institution the degree of Doctor of Medicine with the class of 1896. After graduating he was a resident physician at the Lying-In Hospital (1896-1897); chief of obstetrical clinic (1897-1900); in 1900 he was appointed associate professor of obstetrics, which position he held at the time of his resignation. He is surgeon to Sons of Confederate Veterans of Virginia; consulting surgeon obstetrician to United Charities Hospital of Cambridge, Md., member of the Medical and Chirurgical Faculty of Maryland, etc. He has also spent some time in advance study of pathology in the Johns Hopkins University, and only recently visited the clinics of Europe, where he devoted most of his time to microscopical investigation of the female generative tract.

Dr. Allen has been a prolific writer on his specialty, his writings being published in the medical journals of the United States. He is unmarried. His friends wish him unlimited success in his new field of endeavor. Maryland's loss is Virginia's gain.

## BOOK REVIEWS

**INTERNATIONAL CLINICS.** A Quarterly of Illustrated Clinical Lectures and Especially-Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene and Other Topics of Interest to Students and Practitioners. By leading members of the medical profession throughout the world. Vol. I. Twentieth series. Philadelphia and London: J. B. Lippincott Company. 1910.

This volume contains the latest word on some of the latest and most important developments in medicine. Dr. Hideyo Noguchi, of the Rockefeller Institute for Medical Research, contributes further studies on the serum diagnosis of syphilis, with especial reference to the anti-human hemolytic system. In this article he gives his system of serum diagnosis as now practiced. He states that since its introduction, early in 1909, his system has been tried in over 8500 cases by different investigators. It has been compared with the original Wasserman reaction in 1993 cases of syphilis and parasyphilis. Besides, 1488 cases belonging to the above group of diseases were examined by this system with the clinical controls alone. In regard to non-syphilitic cases, it has been tried on tuberculosis, etc., which have been reported to give occasional positive Wasserman reactions. The method has also been applied to about 1400 miscellaneous cases for diagnosis, and in 550 cases, including various conditions of the eye, ear and backward children. In all instances his results are more accurate, his system giving a somewhat higher percentage of positive reactions than the original Wasserman system.

Another article of more than passing notice is "Symptomatology of Pellagra," by J. J. Watson, M.D., of Columbia, S. C. He attributes the source of the disease to the ingestion of Indian corn infected with certain *Hyphomycetes*. The descriptive matter pertaining to the symptoms is very full, and has the ring of authoritativeness through personal contact with the malady. Illustrations add much to the value of the article. In an article on the "Treatment of Pellagra," J. M. King states that Atoxyl in his hands has given no better results than the other arsenical preparations. Transfusion of blood has been resorted to with but com-

paratively little success. In fact, the article leads one to believe that to the present time no remedy of practical value has been discovered. Consequently, treat symptoms as they arise. Some little attention is given the present status of the tuberculins, the varieties, their diagnostic use, their therapeutic use.

The present volume maintains the high standard of the previous ones. Every article is about a live question, a question relating to the practical aspects of medicine. The editor gives in a compact form that which has been tested during the recent year and not found wanting. The illustrations, though not especially numerous, are exceptionally well executed. The type is easy on the eye and on good paper. Here you receive much information in little space.

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**MEDICAL DIAGNOSIS.** A Manual for Students and Practitioners. By Charles Lyman Greene, M.D., St. Paul, Professor of Medicine and Chief of the Department in the College of Medicine, University of Minnesota; Attending Physician St. Luke's Hospital and the City and County Hospital; Chief of the Medical Clinic in the University Hospital; Member of the Association of American Physicians, the American Therapeutic Association, the American Medical Association; Author of "The Medical Examination for Life Insurance and Its Associated Clinical Methods," etc. Third edition; revised, with seven colored plates and 248 illustrations. Leather, \$3.50 net. Philadelphia and London: P. Blakiston's Son & Co. 1910.

This is one of the best condensed volumes it has been our pleasure to read. The text is written in a clear, lucid style, with no oratorical embellishing, but plenty of good, hard, common sense. All disputed theories are relegated to the ash pile, the space being given over to something of practical import to the student and general practitioner, to whom the book is primarily addressed. All the latest advances in medicine have been included in the text, so that the book is absolutely up to date. It is an ideal reference book for general practitioners who have not the time to wade through more pretentious volumes, because here they can, without much trouble or unnecessary waste of time, find in condensed language that which they desire. The size should also commend it to prospective purchasers, as it can easily be slipped in

one's pocket, and thus be ever handy to refer to during spare moments. Of its many attractions may be mentioned the marginal notes and running page headlines, and the illustrations, small in size, but bountiful in number. These supplement the text materially in clearing up obscure points. Whilst the book is small, it must not be thought for one moment that it is a compend. The subject of internal medicine is covered admirably and thoroughly, and sufficiently fulsome for all practical purposes.

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**EMERGENCY SURGERY.** For the General Practitioner. By John W. Sluss, A.M., M.D., Professor of Anatomy, Indiana University School of Medicine; formerly Professor of Anatomy and Clinical Surgery, Medical College of Indiana; Surgeon to the Indianapolis City Hospital; Surgeon to the City Dispensary; Member of the National Association of Military Surgeons. Second edition; revised and enlarged, with 605 illustrations, some of which are printed in colors. Leather, \$3.50 net. Philadelphia: P. Blakiston's Son & Co. 1910.

Times have changed. Surgery has heretofore been relegated to the realms of the specialist, but now, as the author appropriately states, "surgery is no longer reserved for the elect few. That its beneficence shall be denied a place in every practitioner's art is repugnant to the spirit of the times." Thus realizing the fact that the general practitioner must be equipped to meet emergencies, and even be fairly competent to dare invade the field of legitimate surgery, the author has presented to the general practitioner a book with quite a number of well-accepted rules for his guidance and help. The question of antiseptics, care of instruments, emergency antisepsis for operation in a private house is thoroughly explained. The various anesthetics, their place, method of administering and antidote in case of overdose, have each received due mention, and cannot help but be useful to those to whom the book is directed. A chapter is devoted to sutures (methods and materials); drainage; dressings, bandages and splints; diagnosis and arrest of hemorrhage; subcutaneous wounds; wounds of special regions; treatment of injuries to the hand; injuries to the abdomen; wounds of the heart; first aid on the battlefield; the various fractures; the different dislocations; prostatic abscess; phlegmon; foreign bodies; after-treatment of laparot-

omy; after-treatment of herniotomy; intestinal anastomosis, etc.

The chief merit of the book is utility. Useless verbiage gives way to directness of statement and accuracy of description. The author says what he has to say with as little trimmings as the subject under discussion will permit. Some may think that the chapters on laparotomy, herniotomy, etc., are unnecessary for the general practitioner, but in our opinion they are attractive features of the book, for any physician in an emergency should be prepared to perform these operations. Nothing included in the volume is superfluous, nothing impractical; every line bears a message to the general practitioner. Any success which the book may have or may attain is due entirely to its practicalness. Most of the commoner operations are included in the book, which is of such a size and bound with a material which will easily permit of its slipping into an overcoat pocket, thus permitting its ever presence for quick reference. It admirably meets the requirements for which it was intended, namely, a handbook for general practitioners of medicine who have the courage to operate when necessity demands. The treatment allotted to any one subject must of necessity, owing to the character of the book, be rather limited; yet, in every instance it is sufficiently full for the purpose of the class to which it is directed.

## ITEMS

Dr. John Turner, class of 1892, will spend two months abroad, visiting Mediterranean points.

Mrs. Hannah D. Wilson of Centerville, Md., has announced the engagement of her daughter, Miss Mary Wilson, to Dr. Jacob Wheeler Bird, class of 1907, of Sandy Spring, Md. Miss Wilson is a graduate of the Presbyterian Hospital of Philadelphia Training School for Nurses, and was formerly assistant superintendent of the University Hospital, and more recently connected with the Hospital for the Women of Maryland.

Dr. Cooper R. Drewry, class of 1902, is spending some time in Philadelphia.

Dr. John S. Fulton, class of 1881, has been appointed chairman of the Municipal Tuberculosis Commission. The commission was appointed to make a special study of tuberculosis in Baltimore

and to try and outline a plan of campaign for stamping out of the disease.

Dr. Mactier Warfield, class of 1884, and Mrs. Warfield will close their city home, Howard and Monument streets, July 14 and occupy for the summer Bryn Dun, the residence of Mr. John Dushane, on Roland avenue.

Dr. W. G. Queen, class of 1909, formerly assistant resident physician at the University Hospital, has located on Groveland avenue, West Arlington, where he is engaged in the practice of his profession.

Dr. J. Burr Piggott, class of 1907, has been appointed superintendent of the University Hospital, vice Dr. Robert Parke Bay, class of 1905, resigned. Dr. Piggott has served with credit as assistant surgeon at St. Joseph's Hospital, Baltimore, 1907-1908, assistant resident physician to the University Hospital, 1908-1909, spending the intervening time until his appointment as superintendent at his home in Virginia. Dr. Piggott is thoroughly equipped to assume the duties of his new office, and we feel assured that his friends will be glad to hear of his good fortune.

Dr. Eugene H. Mullan, Passed Assistant Surgeon, U. S. N., was granted 13 days leave of absence from June 17, 1910.

Dr. W. Waters Stonestreet, class of 1906, of Morgantown, W. Va., wrote a letter to the Baltimore *Sun* protesting against the Flexner criticism of the medical schools of Baltimore.

Dr. Jay Ralph Shook, class of 1899, Major, U. S. A., has been ordered to Denver to take the physical test.

Dr. Nathan Winslow, class of 1901, and Mrs. Winslow have returned from a 10 days' trip to Atlantic City.

Dr. Randolph Winslow, class of 1873, and Mrs. Winslow have returned from a visit to Boston, where they attended the commencement exercises of Wellesley College, their daughter, Miss Jane Parry Winslow, being one of the graduates.

Dr. Arthur M. Shipley, class of 1902, was a

guest at the June 21 meeting of the North Carolina Medical Association.

Dr. Charles W. Mitchell, class of 1881, is spending the months of June, July, August and September abroad.

Dr. Howard Elmer Ashbury, class of 1903, has been appointed assistant in surgery in the Johns Hopkins Medical School.

Dr. C. Urban Smith, class of 1889, has resigned as professor of medicine at Maryland Medical College.

Dr. Mackall R. Bruin, class of 1895, has been elected vice-president of the Shenandoah County (Virginia) Medical Society.

Dr. J. Whitridge Williams, class of 1888, has been elected honorary president of the Gynecological and Obstetrical Society of Glasgow, Scotland.

Dr. William Turner Wooten, class of 1899, is one of the instructors at the Nurses' Training School of St. Joseph's Hospital, Hot Springs, Ark.

Miss Anne Elizabeth Chapman, a graduate of the Training School for Nurses, class of 1906, has resigned as superintendent of the Emergency Hospital of Easton, Md.

Dr. Benjamin F. Tefft, Jr., class of 1905, of Anthony, R. I., with Mrs. Tefft and their 11 months' old daughter, is spending the summer at his cottage at Oakland Beach, R. I.

Dr. Allen H. Wright, class of 1906, is located at Stamford, Vt.

Dr. O. Edward Janney, class of 1881, is taking a prominent part in the Friends' Conference at Asbury Park, N. J.

The following members of our alumni attended the meeting of the Talbot County Medical Society July 8: Drs. Arthur M. Shipley, class of 1902; Henry O. Reik, class of 1891; Raymond Downes, class of 1904; Joseph B. Seth, class of 1899; Jas. L. McCormick, class of 1884; William S. Seymour, class of 1895; Joseph A. Ross, class of 1896;

Samuel C. Trippe, class of 1875; S. Kennedy Wilson, class of 1879; Edward R. Trippe, class of 1862; Philip L. Travers, class of 1902; S. Denney Willson, class of 1900, and Charles F. Davidson, class of 1888. A discussion on "Symptoms and Time to Operate for Inflammation of the Mastoid" was led by Dr. Henry O. Reik.

Dr. George E. Bennett, class of 1909, who has been a member of the staff of the Hospital for the Crippled and Deformed of New York, has returned to Baltimore.

Dr. John F. Hawkins, class of 1906, of 1608 South Light street, is recuperating at the University Hospital after an operation for appendicitis.

Dr. Purnell F. Sappington, class of 1887, has been elected president of the Board of Trade of Belair, Md.

Dr. Walter B. Kirk, class of 1893, of Darlington, Md., was a member of a large delegation of Harford countians who called upon the State Roads Commission and urged their purchasing of Conowingo Bridge.

Dr. Harry M. Robinson, class of 1909, is located at 2004 Wilkens avenue, Baltimore, Md.

Dr. N. H. D. Cox, class of 1902, is planning to build a new residence in Arlington at the corner of Park Heights and Rogers avenues.

On June 1, 1910, the one hundred and third annual commencement of the several departments of the University of Maryland was held at the Academy of Music. The scene was an impressive one. On the stage were the members of the faculties in their vari-colored caps and gowns. The candidates for degrees occupied the orchestra. The rest of the theater was given over to the friends and relatives of the graduates. Those who received degrees numbered two hundred and forty-one. We desire particularly to call attention to the large number of college men the University of Maryland deemed worthy to be started on their chosen work. Such an influx into the body politic of educated men is indeed a splendid addition to the potential resources for good of any State, and Maryland is to be con-

gratulated that she has an educational institution with the heritage of a glorious past of more than one hundred years situated in her midst. Many distinguished men have been given by our alma mater to our State and nation; men eminent in medicine, law, pharmacy, dentistry and other walks of life; men who have been a distinct asset for good in the communities in which they have lived; men who have conferred benefits not alone to their country, but also to the whole world. It is not given to many institutions to turn out men who have added to the sum total of human knowledge. We are proud to say that the University of Maryland has this distinction. Any institution would be proud of such men as Henry R. Carter, William T. Councilman, Abbott, Homer Wright, James Carroll, John R. Williams, Nathaniel Kierle, all men who have made the world happier and better by having lived in it.

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Amongst our alumni located in Baltimore county are:

N. H. D. Cox, class of 1902, Arlington.  
 Robert H. Hardesty, class of 1892, Arlington.  
 John H. Drach, class of 1880, Butler.  
 Robert Edward Garrett, class of 1890, Maryland Hospital for the Insane, Catonsville.  
 John Charles Macgill, class of 1891, Catonsville.  
 Arthur H. Mann, Jr., class of 1890, Catonsville.  
 Charles L. Mattfeldt, class of 1886, Catonsville.  
 Marshall B. West, class of 1901; Catonsville.  
 Benjamin R. Benson, class of 1873, Cockeysville.  
 James Edward Benson, class of 1884, Cockeysville.  
 George W. Everhardt, class of 1885, Dickeyville.  
 J. Carroll Monmonier, class of 1897, Dickeyville.  
 James H. Wilson, class of 1868, Fowblesburg.  
 James F. H. Gorsuch, class of 1876, Fork.  
 Joseph S. Baldwin, class of 1874, Freeland.  
 John B. Norris, class of 1866, Freeland.  
 William D. Corse, class of 1887, Gardenville.  
 John S. Green, class of 1883, Giddings.  
 Morris B. Green, class of 1909, Giddings.  
 Robert J. Henry, class of 1866, Glyndon.  
 Edward M. Duncan, class of 1884, Govans.  
 George H. Hocking, class of 1879, Govans.  
 Thomas K. Barber, class of 1865, Granite.  
 Edward G. Darling, class of 1882, Lauraville.  
 Thomas H. Emory, class of 1896, Monkton.  
 Alexander R. Mitchell, class of 1877, Monkton.  
 Josiah Slicer Bowen, class of 1904, Mt. Washington.

A. L. Wilkinson, class of 1903, Raspeburg.  
 Wm. H. H. Campbell, class of 1869, Owings Mills.  
 Frank W. Keating, class of 1896, Owings Mills.  
 Eugene W. Heyde, class of 1892, Parkton.  
 Robert R. Norris, class of 1878, Parkton.  
 Henry A. Naylor, class of 1900, Pikesville.  
 H. L. P. Naylor, class of 1860, Pikesville.  
 William P. Wyse, class of 1886, Pikesville.  
 James W. Gore, class of 1867, Reisterstown.  
 Harry M. Slade, class of 1884, Reisterstown.  
 H. Burton Stevenson, class of 1892, Rider.  
 Henry F. Cassidy, class of 1890, Roland Park.  
 Arthur B. Glascock, class of 1888, Roland Park.  
 Samuel B. Grimes, class of 1897, Roland Park.  
 M. G. Porter, class of 1894, Roland Park.  
 Samuel C. Chew, class of 1855, Roland Park.  
 Carville V. Mace, class of 1897, Rosslyn.  
 Josiah G. Paine, class of 1868, Sunnybrook.  
 J. Clement Clark, class of 1880, Sykesville.  
 William Henry Fisher, class of 1905, Sykesville.  
 Clarence W. Heffinger, class of 1881, Sykesville.  
 Frank W. Lucas, class of 1894, Sykesville.  
 John N. Morris, class of 1893, Sykesville.  
 J. Royston Green, class of 1899, Towson.  
 Henry T. Harrison, class of 1874, Towson.  
 J. Henry Jarrett, class of 1852, Towson.  
 Richard C. Massenburg, class of 1884, Towson.  
 W. McLean Yost, class of 1891, White Hall.

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Members of the class of 1910 have located as follows:

H. S. Anderton, Diboll, Texas.  
 J. W. Abbott, University Hospital.  
 J. M. Blodgett, West Stewartstown, N. H.  
 T. Brooks, Sta. Rita Baja 15, Santiago, Cuba.  
 J. M. Brewer, Owigsbury, Pa.  
 J. F. Byrne, 524 West Mulberry street.  
 G. Caturani, 348 East 116th street, New York.  
 M. L. Cahn, 422 North Greene street.  
 G. C. Coulbourn, Marion, Md.  
 W. S. Conway, Uxbridge, Mass.  
 B. S. Compton, Front Royal, Va.  
 T. D. Crouch, Taylorsville, N. C.  
 J. F. Costas, 629 West Franklin street.  
 F. L. Darrow, Relay, Md.  
 W. B. Fellers, Roanoke, Va.  
 M. J. Fine, University Hospital.  
 F. P. Firey, 711 St. Paul street.  
 H. M. Foster, 415 West 36th street.  
 C. E. Fowble, Bayview Hospital, city.  
 M. J. Fiery, 711 St. Paul street.

J. H. Fiscus, 734 West Fayette street.  
 P. A. Garcia, Arecibo, Porto Rico.  
 W. R. Gardner, Grand Tower, Ill.  
 C. A. Goettling, University Hospital.  
 N. Garb, 137 West Lee street.  
 W. A. Gracie, University Hospital.  
 S. G. Glover, 618 West Lombard street.  
 A. L. Hyatt, Kinston, N. C.  
 M. S. Hanna, Tanta, Egypt.  
 John Trout Herr, St. Joseph's Hospital, Lancaster, Pa.  
 E. B. Howle, 824½ West Lombard street.  
 M. G. Hoffman, University Hospital.  
 B. Kader, 817 Hollins street.  
 R. L. Kennedy, Quincy, Fla.  
 H. N. King, McBee, S. C.  
 E. H. Kloman, University Hospital.  
 L. E. Langley, 1129 Baldwin street, Williamsport, Pa.  
 G. B. Morris, Goldsborough, N. C.  
 T. J. Murray, 109 Blackhall street, New London, Conn.  
 A. R. Mackenzie, Sparrows Point, Md.  
 A. C. McCall, Hebrew Hospital, Baltimore.  
 C. W. McPherson, Haw River, N. C.  
 H. B. Messmore, Uniontown, Pa.  
 M. J. McDermitt, St. Mary's Hospital, Waterbury, Conn.  
 R. D. McMillan, Red Springs, N. C.  
 J. F. Might, Charleroi, Pa.  
 John E. O'Neill, 2526 North Calvert street.  
 M. E. B. Owens, University Hospital.  
 W. B. Parramore, Bayview Hospital, Tubercular Dept.  
 G. A. Parker, Southampton, Pa.  
 H. B. Rowe, Charlotte, N. C.  
 H. LeR. Ramsom, Townline, Pa.  
 L. Rubin, Bayview Hospital, Tubercular Dept.  
 J. G. Runkel, Burlington, Wis.  
 D. G. Rivers, Taylorsville, N. C.  
 J. R. Robertson, University Hospital.  
 H. W. Seelinger, Norfolk, Va.  
 J. V. Shull, Perth Amboy, N. J.  
 H. A. Shimer, Roaring Springs, Pa.  
 G. W. Shipp, Newton, N. C.  
 N. B. Steward, University Hospital.  
 G. L. Stickney, 1612 Park avenue.  
 G. Sawaya, 639 West Lombard street.  
 J. E. Talbott, University Hospital.  
 R. P. Truitt, University Hospital.  
 E. H. Teeter, University Hospital.  
 J. A. Thomason, Fountain Inn, S. C.

J. H. von Dreele, 909 36th street, Hampden, Baltimore.  
 W. L. Van Sant, Kinsale, Va.  
 M. P. Wichard, Hobgood, N. C.  
 W. M. Winters, St. Michael's Hospital, Newark, N. J.  
 Geo. Walter, University Hospital, Baltimore.

## MARRIAGES

Miss Venie C. Weitzell, class of 1895, University Hospital Training School for Nurses, was married on June 16 to Mr. Charles H. McNabb of Cardiff, Md. The ceremony took place at St. Luke's Protestant Episcopal Church, Baltimore, Md.

Dr. Herbert Seth Anderton, class of 1910, was married on June 8, 1910, to Miss Margery Janney Smith of Walbrook, Md. Dr. Anderton was a house student during his last year at the University.

Dr. Felipe A. Garcia, class of 1910, was married to Miss Murray Ethel Robinson June 24. Dr. Garcia is a native of Areciba, Porto Rico. Miss Robinson is the daughter of Mrs. Mary Hill Robinson, 2118 North Charles street, Baltimore. The ceremony was performed by Rev. Bartholomew A. Hartwell at St. Ann's Catholic Church. Dr. and Mrs. Garcia will make their home in San Juan, Porto Rico.

Dr. Robert H. Hargrove, class of 1877, of Robersonville, N. C., was married to Miss Dora Mae Krider of Salisbury, N. C., at the home of Mrs. Charles H. Rawls of Robersonville April 28. Dr. Hargrove received his literary training at Trinity College, Durham, N. C., afterwards graduating at the University of Maryland Medical School.

Dr. Thomas Henry Legg, class of 1907, was married to Miss Evelyn C. Repp May 18. Dr. and Mrs. Legg will reside at Union Bridge, Md.

Mr. and Mrs. Melville William Sterne of 342 North Elm street, Greensboro, N. C., have announced the marriage of their daughter, Miss Nan Steele Sterne, to Dr. James Herbert Bates, class of 1907, of Baltimore, Md. Dr. and Mrs. Bates will reside at 3406 Garrison avenue, Forest Park, Md.

Dr. Lawrence Kolb, class of 1908, was married to Miss Lillian H. Coleman of Baltimore, daughter of Mr. and Mrs. C. W. Coleman, June 9, 1910. Dr. Kolb led his class at the University of Maryland, and was a man held in high esteem by his associates. He was for a time assistant resident physician of the University Hospital. He is now stationed at the Public Health and Marine Hospital at Reedy Island, Port Penn, Delaware. The ceremony took place at St. Michael and All Angels' Church, and was performed by the rector, Rev. Charles E. Fiske. Dr. Henry B. Kolb, brother of the groom, was best man, and Miss Alva G. Coleman, sister of the bride, bridesmaid.

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Dr. Richard Clinton Bunting, class of 1899, was married at Baltimore recently. Dr. Bunting is located at New London, N. C.

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Dr. Joseph Isaac Kemler, class of 1907, was married to Miss Rebecca Macht, daughter of Mr. and Mrs. Ephraim Macht, of 430 North Broadway, Baltimore, Md., June 29, 1910. The ceremony was performed at the home of the bride by Rev. Dr. S. Schaeffer of McCulloh Street Synagogue. Dr. Kemler is located at Hartford, Conn., and was until lately assistant resident physician at the Hebrew Hospital, Baltimore.

## DEATHS

Dr. Claude Van Bibber, class of 1877, died at St. Joseph's Hospital July 11 of nervous trouble. He had been in poor health for some time, which was much aggravated by a fall on the ice in March, 1909. Dr. Van Bibber was born June 27, 1853, and came of a prominent Maryland family. He was an alumnus of Georgetown University, from which institution he received the degree of bachelor of arts. He was visiting physician to St. Agnes' Hospital from 1878 to 1893. He was visiting physician to the Home of the Friendless since 1881, and visiting surgeon to St. Joseph's Hospital since 1895. He was the son of the late Dr. Washington Chew Van Bibber, class of 1845, and brother of the late Dr. John Pierre Van Bibber, class of 1871. He was married in 1893 to Miss Margaret Cohen, daughter of Judge M. L. Cohen of the Supreme Court of New Orleans. He is survived by his widow and three children—Claude, Karl and John Edmond Van Bibber.

Dr. Jesse Wright Downey, class of 1869, died at his home in New Market June 25 from cerebral hemorrhage, aged 62 years. Dr. Downey was educated at Rock Hill College, afterwards graduating at the University of Maryland. He was vice-president of the Medical and Chirurgical Faculty of Maryland in 1892-1893, and was for many years assistant surgeon of the First Regiment of the Maryland National Guard. He was a member of the First Maryland Cavalry, taking part on the Confederate side during the last year of the Civil War.

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Dr. Nathaniel R. Gerry, class of 1864, died at St. Agnes' Hospital, Baltimore, July 2, aged 78 years. Dr. Gerry was born in Rowlandsburg, Cecil county, Maryland, and was a druggist for many years. In 1880 he located at Catonsville, Md., where he remained until his death.

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After a long and hopeless illness, Major Richard Morton Venable, for many years a professor in the law department and regent of the University of Maryland, died at his home in Baltimore, July 10, 1910. Major Venable was born at Cold's Ferry, Charlotte county, Virginia, February 8, 1839, of a well-known Virginia family that traced its ancestry back to an illustrious tree in England. His parents were Richard N. and Magdalen McCampbell Venable. He spent his boyhood in the ordinary Southern manor fashion. He graduated from Hampden-Sidney College in 1857, with the degree of bachelor of arts. This same college conferred upon him in 1859 the degree of master of arts, and in later years, 1888, the honor of LL.D. After leaving Hampden-Sidney he spent two years at the University of Virginia, studying applied mathematics and engineering until the outbreak of the war in 1861, when he left his studies to enlist as a private in the Richmond Howitzers. When the artillery was consolidated into a battalion he became adjutant of the First Virginia Artillery, commanded by Colonel Cabell. He later entered the engineering corps and gained the rank of major, which he bore until his death. He was wounded at the battles of Jenkins Ferry and Seven Pines.

At the conclusion of the Civil War Major Venable received an appointment as Professor of Engineering at the University of Louisiana, from

where he was transferred to the chair of mathematics at Washington and Lee University. He studied law here while teaching, and was graduated in 1868 with the degree of LL.B. In 1869 he came to Baltimore and began the practice of law. In 1871 he formed a partnership with Mr. Joseph Packard, which partnership was dissolved about 1892. Mr. Packard retaining a large general practice, and Major Venable engaging in corporation practice. In 1870 he was elected a professor in the law school of the University of Maryland, which position he resigned in 1905, though remaining upon the Board of Regents. He was succeeded by Prof. John J. Donaldson. He was a trustee of the Johns Hopkins University and Hospital and president of the Park Board of Baltimore city.

Major Venable was a public-spirited citizen, whose influence and work will be much missed. As president of the Park Board he did much to beautify the city, and strongly urged upon the City Council the advisability of adopting the Olmsted suggestion to park the lands along Gwynn's and Jones' falls, Stony run, the Patapsco river, Herring run and Lake Roland, and what has been done in that direction is largely due to his efforts. His work upon the Burnt District Commission was noteworthy. His labors in remodeling streets and bettering conditions at that time would have served to endear him to the hearts of Baltimoreans without his other public endeavors.

As a lawyer he was untiring. His work on "Real Property" is used as a textbook in most American law schools. His speech defining the difference in power between the central government and the States, delivered before the American Bar Association, has been accepted as authoritative, and embodies practically the same ideas as advocated by Ambassador James Bryce.

He was a student all of his life, and was well versed upon most subjects of conversation. He revelled in his library, and his range of subjects ran from Roman history to higher criticisms of the Bible, and to the deepest studies of philosophy.

Major Venable was a man of huge proportions, and from his personal appearance and wit was often compared to Socrates. He knew well how to disarm his opponent with a well-seasoned jest. To whatever he undertook he lent a wonderful breadth of view and foresightedness.

As a citizen he was a man of incorruptible virtue and patriotism, and one of the few men to

whom the stigma of self-seeking could never be attached.

The following tribute was paid to the memory of Major Venable by the Bentztown Bard in the *Baltimore Sun* of July 12, 1910:

#### VENABLE.

He had grown tired and he asked for rest—  
Old rugged lion, the warfare round him prest,  
And light grew weary, and the way was dim  
With blaze of many battlings over him:  
Sweet in the clear, hot sunlight of July  
His lame heart halted—and God closed his eye!

Today in an urn of ashes he'll repose,  
All that is mortal of him—but the rose  
Of grand, true manhood, of his scholar's clutch  
On Wisdom's treasure, will swing back to touch  
The wide environment he influenced so  
In the divine, remembered long ago.

Head like old Homer's, and a fist of thought  
That with a blow of bludgeons ever wrought  
Through conscious masteries of the mental state,  
He was our learned old soldier, grandly great,  
Burning with caustic and full-centered wit  
The old hypocrisies—to see them fit!

Scorning the sycophant with scathings grand,  
Rugged in nature as in head and hand,  
His heart—sore wounded in some far-on strife—  
Beat nobly as a woman's all his life  
For best things ever, and forever right,  
Reaching beyond least knowledge for most light.

There was the storm of battle in his scorn,  
Of shams and makeshifts—just the one straight thing  
For him in nature, and he knew her ring  
Of old, sincere and undeviating, will,  
And loved her broadly—in her sea, her hill,  
Her storm and calm, and old returnings hence  
With sane, self-centered, wide-flung recompense.

He had gone past the time when men have care  
How long they last, or whence or why they fare.  
There comes a time in all men's feelings when  
Interest in life collapses, and they sway  
Unmoved by tragic or by comic play—  
Morning or night or winter time or May—  
Or song or silence, or the night or dawn,  
Or the mere mystery of going on.

But his old, shaggy mentalness ne'er drooped:  
Here was a heart, a mind, that never stooped;  
A face turned forward, never daunted, clear  
Of all lame dogmas, and forever near

The high gods dwelling in that joy of mind  
Where men high solace and contentment find.

Stalwart, and strong, and stainless—ashes, blow  
That were his substance Like a holy snow  
Of incense scattering broadcast where ye list  
A lion heart like his, a head, a fist,  
Filling the earth with huge, great types of men  
Till Venable returns, and we are blest again!

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No. 6

## INTRODUCTION TO COURSE IN SURGERY.

*Lecture Delivered at the University of Maryland  
by Randolph Winslow, M.D., LL.D.,  
Professor of Surgery, University  
of Maryland.*

*Definition.*—Surgery is that branch of medicine which, wholly or in part, treats diseases, injuries and deformities by mechanical or operative means.

The term itself is derived from the Greek word *cheir*, hand; *ergon*, work—meaning a work done by the hand. Formerly the terms chirurgery and chirurgeon were in general use, but these words have been contracted and changed into surgery and surgeon, though we occasionally use the somewhat archaic expression, surgical. In most of the civilized languages the terms employed correspond very closely with the Greek and Latin, and the words chirurgie in French and German, and cirugia in Spanish, are derived from the same original source.

Surgery is of a twofold nature, consisting of a knowledge of the underlying rules governing surgical affections, or the principles of surgery; and the application of this theoretical knowledge to the cure of disease, which is the practice of surgery. Many text-books are inscribed the Principles and Practice of Surgery, or the Science and Art of Surgery. The science of surgery is that division which treats of surgical bacteriology, surgical pathology, the etiology or the causes of disease, the course, changes and alterations, past, present and future of disease and injuries, and the processes of repair. The art of surgery is the application of those principles, which constitute the science, to the treatment of disease, and the repair of injuries as they present themselves in actual practice.

To be able to successfully practise surgery, the student or practitioner must have not only such

theoretical knowledge as can be obtained from text-books, journals and lectures, but this must be supplemented by careful clinical observation and by pathological investigations in the laboratory and dead house. Very few diseases follow the typical course laid down in the text-books, and very few injuries present all the features usually ascribed to them. Clinical experience alone will enable the physician or surgeon to recognize the many variations that occur and to appreciate their significance. Careful notes should also be kept of the cases coming under observation and treatment, for future reference.

*Etiology.*—It is extremely essential that the practitioner should be cognizant of the causes of disease and of the manner of the production of injuries, in order that he may not only arrive at a correct diagnosis, but also forecast the probable result, and institute the proper treatment. For instance, there are certain affections due to the absorption of poisonous substances into the blood, known by the name of sapremia and septicemia. Now when it is remembered that these very grave diseases are generally due to the retention of fluids in operation wounds, or in cavities, which become infected with saprophytic or pathogenic organisms, it follows that when symptoms indicative of these disorders arise after an operation, there is usually retention of such septic fluids, and a further deduction is in regards to the treatment, viz., to remove the cause by cleansing the wound and establishing free drainage, etc. This knowledge also enables us to look ahead and to anticipate this complication by taking the precautions necessary to prevent the accumulation of fluids in wound cavities, or the entrance of deleterious germs, or to destroy them, if infection has already occurred.

*Diagnosis.*—No more important subject can claim the attention of the student than that of diagnosis, the art of discriminating one affection from another. As the compass is to the mariner, so is diagnostic ability to the practitioner. It

must be our constant study to perfect ourselves in this essential art. First of all, a diagnosis ought not to be arrived at hastily, but should be worked out. The physician must not let his mind be influenced by any preconceived idea; his hopes and fears must all be laid aside. His duty is not to plead a cause, but to discover the truth. Very often the truth will be contrary to his wishes, but his duty is still to seek it, and it alone.

Secondly, all the possibilities of a given case must be separately considered, and by a process of elimination, one after another, thrown aside until the most probable is reached. Whilst these two rules are of universal application, it will depend upon the acumen of the observer whether his diagnosis is soon formed or not. As it is impossible to treat, rationally, diseases of which we have no clear understanding, our first effort must be to investigate all cases thoroughly. When a patient applies for treatment our first inquiry should be in regard to the nature and location of the ailment. This serves to direct our attention to the most evident symptoms from the patient's point of view. How long have you been sick? This question will determine whether we have to deal with an acute or chronic malady. It is proper and very important to ask about the cause of the disease or injury, about the direction or force of the blow, or other mechanical cause, about exposure of any kind, by means of which the ailment may have originated. Not only must the organ or tissue first affected be interrogated, but also many others, as it would be useless to treat a rather trivial injury to one part if a serious or even fatal disease affected another part. In case of an injury the sound side should always be examined and compared with the affected side; indeed, in most cases of any kind of involvement of the limbs or joints this should be done. The age, sex, condition of life, occupation, hereditary or acquired taints, all have a direct bearing on the case and must be considered. The surgeon must make use of all his senses; educated sight is, of course, the most important; the sense of touch, "tactus eruditus," is scarcely less valuable; an acute hearing by means of which many internal affections are detected is greatly to be desired. The sense of smell is frequently employed to advantage in the detection of morbid conditions, and in rare instances valuable information may be secured through the sense of taste. I wish especially to urge the cultivation of our unaided

senses in the investigation of disease, but we must also call to our assistance the various instruments of precision, such as the thermometer, hemocytometer, laryngoscope and others too numerous to mention. Of all the methods of investigation, none yield more valuable results than the microscope. In most cases useful information is gained by its employment, and in many cases a correct diagnosis and prognosis can be reached in no other way. Cultivate, then, at every opportunity a familiarity with this indispensable instrument. The urine, feces, vomitus, sputum, saliva, blood and other secretions and discharges, normal and abnormal, will require to be examined carefully by ocular inspection and chemical analysis, as well as by means of the microscope and other scientific appliances.

*Preparation for an Operation.*—Surgical operations should only be undertaken after the exercise of every precaution and care to attain a favorable result and to subject our patients to as little danger and discomfort as possible. The arrangements for a serious operation involve the selection and preparation of a suitable room in which to perform the operation, the preparation of the patient for the operation, the disinfection of the hands and arms of the surgeon and his assistants, and the sterilization of the instruments, dressings and all appliances which may come in contact with the wound. The great danger in all operations is infection, by which is meant the invasion of the wound by deleterious organisms of various kinds, and the effort of the surgeon is to prevent infection. When possible operations should be performed in well-equipped hospitals, where appliances are at hand to meet emergencies as they arise, and where the principles of aseptic surgery can be applied more effectively than in private houses.

As many of you will doubtless have to work in districts where there is no hospital, and all of you will have patients who will refuse to go to a hospital, it is important that you should be able to carry out the technique of clean or aseptic surgery in the houses of your patients. In the city a competent nurse can be obtained, who will take charge of the operating room and make all necessary preparations. In rural districts these details must be entrusted to those who have had no training and possess no knowledge of surgical technique. A room with a good light should be selected, sufficiently heated to be comfortable.

The carpets should be taken up or covered with sheets, the curtains removed and all articles of furniture taken out except such as may be useful during the operation. In many cases it will be desirable to whitewash the walls of the room or wash them off with bichloride, 1-1000, or carbolic, 5 per cent., solutions. The floor and wood-work should be scrubbed with bichloride solutions, as well as articles of furniture, which may remain in the room. Where this is not done everything should be covered over with clean sheets or cloths. It will be frequently necessary to improvise an operating table, and usually a narrow kitchen table, properly cleaned and covered with a blanket and a clean sheet, will answer every purpose. Sometimes it may be necessary to place a few boards across the backs of chairs, and I know one graduate of this school practicing in the country, who, in the absence of any better table, took a door off its hinges and put it on two wood-sawyers' horses and performed his operation successfully. Of course, a regular surgeon's operating table would be much handier and more satisfactory than these makeshifts, but I am only indicating to you that good work may be done with such appliances as may be at hand. Tables for instruments can usually be found in any house, or in the absence of anything better, bureaus, washstands, or even chairs, can be used after having been washed off and covered with towels wet with a 1-1000 bichloride solution. China wash basins and shallow dishes should be scalded and cleaned, boiled if possible, and may be used for disinfecting purposes and for instruments. In hospitals all gowns, sheets, towels and dressings of all kinds are subjected to live steam sterilization under heavy pressure. In outside work, and especially in the country, it may not be possible to obtain this thorough sterilization of such articles, but we may usually approximate this result by the use of an Arnold's, the Rochester or other portable sterilizer. Where nothing better can be done, sheets and other large cloths may be placed in an oven and subjected to dry heat, and towels and dressings may be placed in bichloride solution and used wet. In operating in private houses it will be desirable to keep a tin wash boiler with boiling water on the fire, and another receptacle containing cooled boiled water should also be at hand for instant use.

*Preparation of a Patient for an Operation.—* Except when unavoidable, patients should always

be carefully prepared beforehand for surgical operations. In some cases, such as those of strangulated hernia, acute appendicitis and accidents, it is necessary to proceed at once, with only such preparation as may be done on the operating table. In most instances no such haste is necessary, and we have time to observe our patients and to choose a favorable time for operation. First of all the general condition of the patient should be carefully examined, and especially the condition of the kidneys, heart and lungs must be ascertained. If the kidneys are diseased, as shown by the presence of albumen, tube casts or pus in the urine, the prognosis is rendered much more unfavorable and an operation of expediency may not be justifiable. Sugar in the urine likewise is an unfavorable symptom, and diabetic patients are especially liable to go into a fatal coma. The presence of diacetic acid, which may be ascertained by the addition of a few drops of the tincture of ferric chloride to a test tube with urine, when the mixture will assume a port wine color, prohibits an operation. The condition of the heart is, perhaps, of equal importance with that of the kidneys, and patients with serious valvular or nervous derangements of this organ are not good subjects for an operation and are liable to die under an anesthetic. The lungs may be affected very materially and still not be a barrier to operations of necessity or great utility. The presence of pneumonia or of a severe bronchitis or of tuberculous cavities will usually be prohibitive of an operation, except such as must be done at once to avert impending death. The condition of the blood vessels should also be ascertained, especially in persons in middle and advanced life. The presence of marked arteriosclerosis is a very unfavorable prognostic symptom, and patients suffering therefrom are especially liable to die of suppression of urine. The blood will frequently require to be examined, both for organisms of various kinds, as the malarial, or the Widal reaction, as well as to determine the relative proportion of the red and white cells. Marked anemia should postpone an operation when possible. The percentage of hemoglobin should be estimated in such cases, and if it is as low as 30 an operation is contraindicated, as the result is almost invariably fatal. A count of the white blood cells is of value in cases of suspected abscess, though it is not an infallible guide. It at least may serve to direct

our attention in the right direction. The normal number of leucocytes ranges from 7500-8000 to the cubic millimeter, and in abscess it may vary from this to 30,000 or more. Obese patients do not stand operations well. A patient who is about to undergo an operation of any gravity should be in a hospital, or at least restrained at home, and kept in bed 18 or 24 hours previous to the time of the operation. A purgative should be given over night, and if it has not acted freely by the next morning an enema should be administered. The part to be operated on should be shaved whether it is covered with hair or not, as by this means a vast amount of lanugo, hair, epithelium, grease and dirt is removed. Any good soap may be used for cleaning the skin, but the green potash soap is perhaps preferable. The shaving and cleansing of the patient should be preceded by a general bath when possible, and the afternoon or night before the operation he should be shaved, scrubbed with soap, hot water and a stiff brush or gauze. Not only the immediate site of the operation should be cleansed, but a wide area around it in every direction. After thorough scrubbing he may be washed off with ether to dissolve the oil of the skin and alcohol or turpentine, and again washed with 1-1000 bichloride, and towels wet with this solution placed on and around the cleansed area and allowed to remain until the time of the operation. In some instances where the part to be operated on is very painful, or the patient very nervous, it may be prudent to wait until the patient is anesthetized before subjecting him to the cleansing processes detailed above. Attention to the passage of urine should also be given, and just previous to being taken into the operating room the urine should be voided or drawn. If the operation is to be done at any time before the middle of the day, no food should be given the patient in order that the stomach may be empty. If the operation is not to be done early, a glass of milk or cup of tea or coffee may be taken early in the morning. About half an hour before the beginning of an anesthetic I give a hypodermic injection of morphia, gr. one-quarter, combined with atropia, gr. one hundred and fiftieth, or of atropine, gr. one hundredth by itself, in order to lessen the effect of the anesthetic on the heart.

After the patient has been placed on the operating table, and usually after he is under the influence of an anesthetic, the operative area is again

carefully cleansed, and if need be shaved and disinfected in the manner already mentioned and then covered with sterile towels. The patient's body should be as little exposed as possible, and those parts not concerned in the operation should be carefully protected with blankets or clothing to conserve the body heat. Finally sterile sheets should be placed over the whole body, leaving only sufficient space for the operative work. The infection of a clean operation wound is usually due to some lack of care, some break in the technique of aseptic surgery, by the surgeon or his assistants, hence the preparation of the operator and his assistants is a matter of great importance. Great care should be given to the cleansing of the hands and arms of those who come into contact with the area of the operation, the instruments or the dressings. The nails should be kept trimmed and especial care should be taken to remove any collection of dirt beneath them. The surgeon and assistants should scrub their hands and arms thoroughly in hot water, running or frequently changed, with a brush and green soap or other good soap. Ten minutes at least should be devoted to this ablution, especial care being given to the nails and various creases and clefts of the fingers. When possible the hand brushes and soap should be sterilized before they are used. After scrubbing the hands and arms, gowns or sterile suits should be put on, including caps or head cloths and masks for the face, mouth and nose to prevent saliva and breath from gaining access to the wound—"Saliva contains more germs than the worst sewage." It is not well for surgeons to wear much, if any beard, and when a long beard is worn it should be covered as much as possible with gauze or other sterile material to prevent contamination of the wound from this source. After scrubbing and dressing in sterile gowns, the hands and arms must be immersed in a bichloride 1-1000 solution for several minutes. Some operators make use of permanganate of potash and oxalic acid in addition to the methods mentioned above, but I do not think this is necessary. Harrington's antiseptic mixture is, however, very effective for the disinfection of the hands and skin. This consists of commercial alcohol, 640 cc; strong hydrochloric acid, 60 cc; water, 300 cc; corrosive sublimate, 0.8 gramme. It is very desirable for those who are to come in contact with the wound, viz., the operator, his immediate assistants and the instrument handler

to wear rubber gloves. These should be sterilized by boiling and put on after the careful cleansing and disinfection mentioned above. After such disinfection the person is said to be "clean" and he must not touch anything which has not been sterilized. The carrying out of the details of aseptic work is at first difficult and tedious, but gradually one begets an "aseptic conscience" and learns to avoid the errors of technique. It is well at operations to have also a "dirty" man, that is, one who can assist the anesthetizer or do anything required about the room, but he must not be concerned immediately with the operation.

All metallic instruments should be sterilized by placing them in a suitable pan and boiling them in a one per cent. carbonate of soda solution, or they may be subjected to the action of live steam in a sterilizer. They should be boiled at least ten minutes. Instruments with wooden, ivory, bone or rubber handles will probably be injured by boiling and should be placed in a 5 per cent. carbolic acid solution or a 2 per cent. solution of formalin. Steel instruments should not be immersed in bichloride solutions, as it corrodes them, but nickel instruments are not injured by a short immersion in mercurial solutions. Gum bougies and whalebone guides can be placed in carbolic or bichloride solutions for 10 to 30 minutes before using them. Ligatures and sutures of silk, silkworm gut and silver wire should be boiled; catgut and kangaroo tendon can be obtained from reliable manufacturers or may be prepared at the hospital. Dressings of gauze, absorbent cotton and ordinary brown cotton can be sterilized by steam, or in the absence of facilities for sterilization the gauze may be soaked in antiseptic solutions and wrung dry and placed on the wound. Reasonably reliable gauze dressings may be obtained from the large manufacturing houses.

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Dr. Henry Welsh Wickes, class of 1892, passed-assistant surgeon, P. H. & M. H. S., was granted one month's leave of absence from July 15, 1910.

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Dr. Louis McLane Tiffany, class of 1868, is at Magnolia, Mass., where he will spend the remainder of August.

## REPORT OF 76 CASES OF TYPHOID FEVER TREATED IN THE HEBREW HOSPITAL.\*

BY SAMUEL H. LONG, M.D.

The following is a statistical report of the typhoid fever cases treated in the Hebrew Hospital from October, 1908, to December, 1909. Sixty-three per cent. of the cases were admitted during July, August, September and October. The greatest number of cases admitted during one month was in August, 1909, when there were admitted 19 cases. Number of admissions each month were as follows:

March, 1 case; April, 2 cases; May, 2 cases; June, 2 cases; July, 9 cases; August, 19 cases; September, 9 cases; October, 20 cases (1908-1909); November, 9 cases (1908-1909); December, 3 cases (1908-1909).

The ages of the patients were as follows:

1-10 years, 14 cases; 11-20 years, 31 cases; 21-30 years, 12 cases; 31-40 years, 14 cases; 42 years, 1 case; 46 years, 2 cases; 48 years, 1 case; 56 years, 1 case; the youngest case being  $2\frac{1}{2}$  years old. The greatest number of cases occurred in the third decade of life.

*Sex.*—Males, 44; females, 32. There are many reasons given by authorities for the preponderance for males with typhoid treated in hospitals. McCrae states that males are more exposed to the disease by their more active life. Osler states that males are more frequently admitted to hospitals. The latter was not borne out according to our statistics.

The incubation period varied from one to two weeks with symptoms of malaise. The time of onset of most of the cases was indefinite, as patients could not tell when they became ill. The symptoms of onset were vague; predominant were loss of appetite in all the cases, headache in 59, malaise in 53, nausea and vomiting in 20, chills in 16, epistaxis in 10, diarrhea in 11, abdominal pain in 8. Of the 10 cases in which nose bleed was noted, 6 had recurrence sometime during the course of the disease, but in none was it so severe as to require treatment. Epistaxis, when taken with the other symptoms, is of good diagnostic value.

Peculiar modes of onset were noted in several of the cases. In one case of ambulatory typhoid

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\*Read before University of Maryland Medical Society March 15, 1910.

the patient was attending his daughter's funeral who had died of typhoid fever, when he was suddenly seized with pain in the abdomen, etc. Patient was rushed to the hospital, operated upon for perforation, and incidentally, I may add, that the patient made a complete recovery. In our youngest case the onset was with vomiting, diarrhea and meningeal symptoms—retraction of the head, nystagmus, painful and rigid spine; positive Kernig's. Spinal culture was made, fluid obtained under increased pressure, but smears and cultures were negative. Another case came in complaining of joint symptoms; both knees and ankles painful and tender to touch; no redness or swelling; temperature on admission 101.2°. He was put on large doses of salicylates, temperature dropped to 99°, and thereafter oscillated between normal and 99.3° for three days. As patient had no more symptoms, salicylates were discontinued and temperature jumped to 104.2° in four hours. On examination abdomen, chest, back and arms were practically covered with a profuse eruption of rose spots. From then on patient had typical typhoid symptoms, temperature lasted 31 days, when patient was discharged cured.

The typical step ladder ascent of temperature described in text-books was noted in three of our five cases which had relapses. Most of our patients were admitted in the second or third week of the disease and temperature on entrance was usually between 103° and 104°. The highest temperature noted was 107.3°, which occurred in two of our fatal cases just before death. In two cases the reading was never above 101°, although both were typical cases of typhoid fever. The temperature was continuous in the majority of cases until the end of the third week, when it began to assume an up-and-down character, the morning temperature being from 1 to 2½ degrees lower than the previous evening temperature, and the evening rise gradually becoming lower. An unusual decline of temperature was noted in one case complicated by pregnancy. This patient began to have intestinal hemorrhages in the third week of the disease. Temperature dropped after the hemorrhages and remained lower, general condition remaining excellent. Post typhoidal rises of temperature from 101.3° to 102° was noted in six cases. These caused fear of relapse, but lasted only a few hours and then returned to normal. No definite cause could

be found, but we assigned the rise to too many visitors, change of diet, sitting up, etc.

The pulse rate was low when compared to temperature. Average maximum rate was 125 in uncomplicated cases when temperature ranged between 104 to 106. Dicrotism was noted in all cases admitted from the end of the first to the end of the second week of the disease. Later in the disease the pulse became soft and compressible. During convalescence pulse rate became slow, and in many of the cases abnormally so. One boy, aged 14, had a pulse rate during convalescence ranging between 50 and 60; general condition was excellent. When hemorrhage or perforation occurred the pulse rate became accelerated. This was more marked in cases of hemorrhage and the pulse rate increased quicker than in perforation. Tension decreased in hemorrhage and blood pressure gradually rose in perforation until symptoms of a collapse set in when pressure began to fall rapidly.

Appetite was capricious or lost in all of the cases. A common complaint was dryness and bad taste in mouth. The first was marked, especially in those cases which had high temperature, even when delirious. In only those cases which were markedly toxic was there difficulty in making them take sufficient water. None of the cases were hungry while fever lasted, and even during convalescence the avaricious appetite mentioned in text-books was not noted. This may be explained by the liberal feeding of our typhoid patients.

The tongue was coated in all but two of the cases, but by keeping mouth washed the tongue did not assume the marked coating usually seen. Tremor of the tongue was noted in 54 of the cases. The condition of the tongue can be taken as an index of the impression of the toxins on the nervous system. In the markedly toxic cases the tongue was protruded slowly and for only a short distance markedly tremulous, and patients would forget to draw tongue back unless told to do so. The teeth were coated with sordes, especially in cases which came in late in the disease. Lips were dry and cracked, gums spongy and bled easily. Frequent mouth washings usually remedied the above. Acute glossitis occurred in only two cases, and in neither was surgical interference required. Ulceration of the soft palate was noted in one case. Herpes about lips was seen in only one of the 76 cases.

Diarrhea during the course of the fever was noted in 35 per cent., and in only one case, complicated by hemorrhage, was this symptom severe. Diarrhea was an early symptom, occurring mainly in the first or second week of the disease. Average number of stools, six a day.

Constipation occurred at some period of the disease in 68 per cent. of the cases and is a more frequent symptom than diarrhea. This is a late symptom, and in three cases was so severe as to demand the manual removal of hard fecal masses.

Abdominal pain occurred in 48.6 per cent. and was explained by perforation, hemorrhage, tympanites, diarrhea and constipation, but in at least one-half of the cases the pain could not be explained. One patient especially, a young girl, had the entire staff at a nervous tension, as she constantly complained of abdominal pain. Patient was of a marked nervous temperament. Pain usually occurred in left hypochondriac or right iliac region. Tenderness was elicited in the above areas in nearly every case. Abdominal distension of any marked degree was noted in 29 per cent. This symptom was present in every case which was complicated by hemorrhage or perforation.

The sensibilities were obtunded in every severe case; hearing, taste and olfactory senses seemed to be affected early. Delirium of varying degrees was present in 29 per cent. Stupor was noted in three cases. Delirium was mainly of a mild and intermittent character, patients when addressed answering in a rational manner. Sub-sultus tendinum was noted in only those cases which were markedly toxic. Bronchitis was noted in 35½ per cent., occurring mainly at the beginning of the disease, and in none of our cases so severe as to mask the other cases.

The skin was hot and dry. Sweating occurred in a few of the cases which had chills. Definite rose spots were seen in 59.2 per cent. This is rather a low percentage, but many of our patients came in late in the disease. In three cases rose spots were profuse, almost a general eruption on abdomen, back, arms and thighs being noted. There occurred in children, during convalescence, a branny desquamation resembling that occurring in the exanthematosous diseases, especially measles. Bed sores were noted in 5.2 per cent. Two of these developed in the hospital. In none was the ulceration severe. The largest was 1½ inches in diameter and very superficial. All yielded readily to treatment. The location in all cases was over

the sacrum. Reddening of skin was noted over bony prominences—the sacrum, crest of iliac bones, great trochanters and elbows, but erosions of the skin were prevented by treatment.

The spleen was felt below the costal margin in 56.5 per cent. In several cases the spleen was enormously enlarged. The spleen could not be palpated in many cases on account of the shape of the chest. This organ was found enlarged at all autopsies.

Febrile albuminuria was noted in 26.3 per cent. Albumen was present in only small quantities and cleared up during convalescence. Nephritis was not noted.

Widal's reaction was noted in 86.8 per cent. This was a valuable aid to diagnosis, especially as many cases gave positive tests on admission.

The leucocyte count in non-complicated cases varied between 3400 and 9600, low counts being the rule. Whenever a count over 9000 occurred complication was looked for.

A differential diagnosis must be made between typhoid fever and the following diseases: Malaria, miliary tuberculosis, acute endocarditis, osteomyelitis, septicemia, influenza, pneumonia, pleurisy, appendicitis, etc.

In a case of malignant endocarditis a differential diagnosis could not be reached on the clinical findings, as the patient was in a typhoidal state and the history could not be obtained. Pulse rate was rapid, soft and compressible, rather quick for the temperature. Patient had red spots on abdomen, which resembled the rose spots of typhoid; spleen was enlarged, heart showed involvement, which was thought to be a complication of typhoid, and a leucocyte count of 12,000 would thus be accounted for. This case will be reported in detail at the end of the paper.

The complications noted were as follows: Intestinal hemorrhage, 6.6 per cent.; perforation, 7.9 per cent.; pleurisy, 3.9 per cent.; phlebitis, 2.6 per cent.; otitis media, 2.6 per cent.; enlargement of the thyroid gland, 2.6 per cent.; glossitis, 2.6 per cent.; ulceration of the palate, 1.3 per cent.; loss of hearing, 1.3 per cent.; periostitis, 1.3 per cent.; perichondritis of the cartilage of the ear, 1.3 per cent.

The hemorrhages mentioned occurred in five cases, two males and three females, at the ages of 30, 32, 35, 36, 48. It is noteworthy that hemorrhage is more common in adults, especially in the fourth and fifth decade of life. Only one case

died from hemorrhage, and even in this case toxemia was probably a more important factor in the cause of death than the hemorrhage. Three of the cases had two distinct hemorrhages, one had three and one had one. Diarrhea was a common accompaniment of hemorrhage, occurring in three of the five cases. Hemorrhage occurred in the second week in one case, in the third week in two cases, in the fourth week in two cases. One case perforated three weeks after hemorrhage and died of a general peritonitis.

Six cases of perforation occurred. These cases have been fully reported by Dr. Charles Bagley, Jr., and will only be mentioned. Of these four were operated upon, with three recoveries and one death. Of the other two, one was brought in moribund and died before operation could be performed, and the other died of toxemia (apparently), and perforation was found on autopsy. One patient, who had an acute exacerbation of a chronic endocarditis, due to rheumatism upon admission to the hospital, perforated in the fourth week. This patient was operated upon, and two days later developed a pleurisy, but finally made a complete recovery. Only one symptom of perforation will be emphasized here, namely, pain. Too much attention cannot be paid to abdominal pain occurring in typhoid fever. The pain of perforation may be of varying intensity and, especially in markedly toxic cases, may be so mild as to pass notice. The pain is sudden in onset and may last for only a short time. It is deplorable that we have to depend on a patient whose sensibilities are obtunded for this, our first and most important symptom of perforation.

Pleurisy, complicating typhoid fever, occurred in three cases; two were of the fibrinous variety and one with effusion.

Phlebitis occurred in two cases, the left lower extremity being affected in both. The symptoms were pain, edema and slight rise of temperature. Both cases were mild in character and cleared up on elevation and perfect rest of limb.

Otitis media occurred in two cases; paracentesis was performed in both. Cultures from ear were negative as to typhoid bacilli.

Enlargement of the thyroid gland was noted in two cases, slightly painful, but no other symptoms. This disappeared in two or three days.

Loss of hearing occurred in one case. Patient

was discharged, still complaining of defective hearing in right ear.

Periostitis occurred in one case. The anterior surface of the right tibia was affected. Redness, pain and swelling noted. This complication occurred during convalescence and lasted two weeks, disappearing under local treatment.

A very interesting condition occurred in one case, namely, perichondritis of the cartilage of the left ear. Auricle markedly swollen and painful.

Two cases were complicated with pregnancy, both multiparous women. The first occurred in the mother of a family of six, five of which were treated in the Hebrew Hospital for typhoid fever. This patient was six months pregnant. She had two intestinal hemorrhages in the fourth week of the disease. Patient discharged cured, and about two months later gave birth to a healthy boy. Unfortunately we had lost track of the patient, so could not make a Widal or culture of the child's blood. The second case was  $7\frac{1}{2}$  months pregnant and gave birth to a healthy girl baby at term. On the birth of baby mother's temperature had been normal 10 days. Blood taken from the cord gave a very suggestive Widal. We were very fortunate with our two cases of pregnancy complicating typhoid, as the prognosis is usually grave, especially when typhoid occurs late in pregnancy.

Relapses occurred in 6.8 per cent. In three of the above cases the rise of temperature was the typical stepladder variety. In the other two cases the rise was sudden. Average duration of primary attack, 29 days, and average relapse, 15 days, and average interval of apyrexia, 6 days. Average height of temperature reached  $103.2^{\circ}$ . None of the cases of relapse proved fatal, but in every case was milder than the primary attack. A diagnosis of relapse was made on the recurrence of the fever, not due to any complication, recurrence of rose spots and re-enlargement of the spleen. Rose spots was noticed in all but one case. One case of relapse occurred in a boy, aged 12, three weeks after perforation and lasted 14 days.

Of the 76 cases treated the average duration of the disease was 43 days, average stay in the hospital was 34 days, shortest stay 14 days, and longest 92 days. Six cases died, making a mortality of 7.9 per cent. Causes of death were as follows: Toxemia, 1 case; toxemia and terminal pneumonia, 1 case; toxemia and hemorrhage, 1

case; toxemia and on autopsy one perforation found, 1 case; perforation, 2 cases.

CASE OF MALIGNANT ENDOCARDITIS DIAGNOSED AS  
TYPHOID FEVER.

L. K., age 24, male.

Admitted to the hospital, October 24, 1909, complaining of fever and nose bleed.

Patient is a foreigner, cannot speak English and is delirious. No personal history obtainable aside from the fact that he has been ailing for two weeks, and about six to seven days ago took to bed with a high fever. Had several attacks of epistaxis, and also a slight cough.

*Physical Examination.*—Patient is a rather poorly nourished male adult of about 130 pounds weight, is delirious and subsultus tendinum is marked. Has a very anemic appearance and is asthenic. Nose bleeding during examination.

*Eyes.*—Pupils dilated, react sluggishly to light and accommodation. Cornea has a glassy appearance.

*Mouth.*—Lips and mucous membranes somewhat cyanotic. No herpes. Teeth very poor and heavily coated with sordes.

*Tongue.*—Tremulous and markedly coated with a dirty mucoid deposit.

*Neck.*—Carotid pulsations are tumultuous.

*Chest.*—Negative except at bases posteriorly. Some moist rales are heard. Respiratory excursions hurried, shallow, but equal.

*Heart.*—P. M. I. at 5th left I. S. both visible and palpable in the mammary line. Systolic retraction is very marked, extending from the second to the fifth interspaces. Auscultation elicits a most rapid heart rate, the sounds at the apex being loud, booming and of a somewhat musical quality. At the base both the second aortic and pulmonic sounds are accentuated. On percussion cardiac area of dullness is not enlarged.

*Abdomen.*—Fair amount of subcutaneous fat, several rose-colored spots are present, no tenderness or painful areas elicited on superficial and deep palpation. No muscular rigidity. Spleen made out easily and edge comes  $1\frac{1}{2}$  fingers breadth below costal margin. Liver not enlarged.

*Genitals, extremities and skin normal.*

*Pulse.*—Hardly perceptible at the right wrist, volume poor, tension very low. No arterio-sclerosis.

Temperature on admission,  $105.3^{\circ}$ .

October 25, 1909, 4 A. M.

Patient has not rallied, condition much worse, pulse barely perceptible. Does not respond to stimulation. Death occurred at 10.45 A. M.

*Clinical Diagnosis.*—Typhoid fever.

*Immediate Cause of Death.*—Toxemia.

*Urinalysis.*—Negative.

W. B. C., 12,000.

Widal, negative.

*Autopsy in Brief.*—Heart considerably hypertrophied. Aortic valve, left cusp, thickened and perforated at both extremities, holes admitting a match stick. Right cusp, thickened. At both ends holes twice as large as in left. Anterior cusp, thickened and just in center is an ulcer one cm. by  $4\text{-}10$  cm.,  $\frac{1}{2}$  cm. from edge on the auricular surface.

Spleen very much enlarged. Amyloid degeneration, extreme chronic passive congestion, kidneys enlarged, chronic passive congestion. Liver enlarged, biliary pigmentation, chronic passive congestion. Intestines normal. Cultures from the heart show *staphylococcus aureus*.

*Anatomical Diagnosis.*—Malignant endocarditis with resultant chronic passive congestion of above mentioned organs.

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In a letter to Doctor Coale, Dr. W. Culbert Lyon, class of 1907, reports that he has been traveling ever since he last saw Doctor Coale, one evening at the Baltimore Club, but at last had arrived safely at Manila. The trip across was tedious, but very interesting at times when the ship stopped at various native towns where there are posts. At Cebu Doctor Lyon took a bull cart ride to a neighboring native village, five miles distant, and found there an alumnus of the University, Dr. N. S. Taqy-Ud-Din, a Syrian, who practices there. Doctor Lyon went to Doctor Taqy-Ud-Din's office just at his office hours, and he was seeing his patients (5 or 6) just in his underwear, and short drawers at that. Doctor Lyon comments that "it sure did look good to see his sheepskin hanging on the wall of his primitive Spanish style home (stable occupying the first floor)." Doctor Lyon also met Dr. William Lee Hart, class of 1906, who is in the service, and stationed at Ormoc. Doctor Lyon is ordered to Mindanao, the Moro district, three other medical men being ordered with him to accompany two battalions of troops, who expect to see some action, as there was quite a fight in that district in April.

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, MD., AUGUST 15, 1910.

## WHAT IS A UNIVERSITY?

In view of the fact that considerable diversity of opinion prevails as to what constitutes a university, we have thought it proper to discuss the matter briefly here. The term university was first used in the thirteenth century, and originally meant an association or corporation of masters and scholars. It did not have reference to any universality of knowledge or of teaching. In 1221, A. D., we find the term officially used, "Nos. universitas magistrorum et scholarium Parisen-sium," and since that time institutions of higher learning, especially when consisting of various colleges or faculties, have been called universities.

In England the universities are for the most part aggregations of colleges, more or less independent, but associated under a central board or senate which confers all degrees and honors. The relation of the colleges to the university being very similar to that of the States to the Federal Union in this country.

In Germany the universities are State institutions, and are controlled by the Government. They consist of various faculties working in harmony and under one jurisdiction.

In this country the term university has been applied rather loosely to institutions of very diverse characteristics. In some cases colleges or schools of liberal arts are called universities without there being any associated faculties or other departments; in other cases professional schools assume the title of universities without having any school of liberal arts.

It has been said recently by a self-appointed arbiter that a university must arise from a school of arts and sciences. This is a bald assertion not

sustained by facts. Huxley said in an address at the Academy of Music in Baltimore, in 1876, a university does not consist of buildings, but of men; and this idea was still further narrowed down by the late President Garfield, who said his idea of a university was a log in the woods with Mark Hopkins on one end of it and a bright boy on the other. Perhaps few persons could give a more authoritative definition of a university than the late Daniel C. Gilman, the organizer of great universities. His definition of a university is "An institution for the promotion of higher education by means of instruction, the encouragement of literary and scientific investigation, the collection of books and apparatus, and the bestowal of degrees." It would seem that a university must be a chartered institution for the promotion of higher learning, consisting of several departments or faculties united under one government and working in unison. Some institutions, beginning as colleges of arts, eventually add other departments and assume the title and functions of universities; thus Harvard University began as Harvard College, and even the date of its assumption of the name and functions of a university are problematical, as is shown by the following quotation from a letter to Professor Cordell from the secretary of President Eliot: "I suppose it is impossible for anyone to fix a time when the college can be said to have become the university. If, however, you regard the establishment of instruction in one or all of the three great branches of theology, law and medicine as an essential characteristic of a university, you must select the date that in your judgment best accords with that definition."

In the Eastern States the universities, though chartered by the State, are private corporations over which the State has no control; in most of the Southern and Western States the universities are State institutions supported by the State, and forming the capstone of the educational system of the State. The University of Maryland was chartered as such by the State in 1812, and was endowed with all the functions of a university, but, though bearing the name of the State, it has received a very beggarly assistance from the State. Notwithstanding this, however, it has exercised the functions of a university as defined by Doctor Gilman, and is so doing to an eminent degree at this time. It "is an institution for the promotion of higher education by means of in-

struction, the encouragement of literary and scientific investigation, the collection of books and apparatus, and the bestowal of degrees." Hampered by lack of adequate financial endowment, it has, nevertheless, done a great work for science and humanity; and if an institution is to be judged by the men who have been turned out by it, our university has no cause to be ashamed of its history or to apologize for its existence.

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#### THE ONE HUNDRED AND FOURTH ANNUAL SESSION.

The one hundred and fourth regular session of the medical department of the University of Maryland, according to the annual announcement which has just been issued, will begin October 3, 1910. It is too early as yet to predict the attendance, but from present prospects the enrollment will be fully up to normal. No material changes have been made either in the personnel of the faculty or in the curriculum.

Bearing in mind our function of producing practical physicians, the curriculum, as heretofore, has been so arranged as to give a proper balance between the purely theoretical and practical branches. The catalogue lays especial emphasis on the clinical facilities offered—the University Hospital, which is the property of the Faculty of Physic, a general hospital devoted to surgical and medical cases and the specialties; the University Dispensary, or out-patient department, where more than 25,500 visits were made by patients during the past year, all of which material was available for teaching purposes; the Presbyterian Ear, Eye and Throat Hospital, the Hospital for the Relief of Crippled and Deformed Children, and Bayview Hospital. The absence of the names of John P. Poe and Richard M. Venable from the list of regents is particularly lamentable. These men had labored long and faithfully for the uplifting of the University, and their loss is incalculable. Death was the only agent which could force them to forego their long and useful service to the institution. But from the names remaining we are assured that the institution will, as heretofore, be managed with the same wise conservatism, that there will be no chaotic changes, that evolution will be gradual and orderly, and in the present our dear alma mater, under the guidance of her present stewards, will occupy as eminent and lofty position among her sister institutions as in the past.

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#### CORRESPONDENCE

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##### A TRIP TO NEW ENGLAND.

The occasion of the graduation of my daughter, Miss Jane Parry Winslow, at Wellesley College, Massachusetts, on June 21st, afforded me a sufficient excuse for making a brief visit to New England, and especially to some of the points of interest in and around Boston. Leaving Baltimore in the evening one arrives in Boston early the next morning if he takes a through sleeper, or he may leave earlier in the day and catch the Fall River steamboat at New York, and after a pleasant and restful night on board reach Boston the next morning. From there to Wellesley is a 30-minute ride. The village derives its importance from the fact that there is located Wellesley College, one of the largest colleges for women in this country. The college is most picturesquely situated on an estate of over 400 acres, consisting of numerous hills and vales, with beautiful Lake Waban nestling at the foot of the hills. The buildings are numerous, large and handsome, and are situated on the crests of the hills at a considerable elevation. Between 1300 and 1400 young ladies from all parts of the United States and from some foreign countries are in attendance at this institution, and a large waiting list is ready to fill vacancies as they occur. The grade of the college is necessarily high, as there are many more applicants for admission than can be accommodated. The commencement ceremonies occupy a week, but I only reached there the day before the graduating exercises. On that day there was an allegorical dance by a large number of the young ladies on the greensward, and in the evening an excellent open-air theatrical performance on the shore of the lake, which afforded a beautiful setting for the play.

On June 21 a huge crowd assembled to witness the graduation exercises. These were held in the beautiful college chapel, which was, however, entirely too small to accommodate the visitors. Two hundred and sixty-seven young women, in caps and gowns, received the degree of Bachelor, and six that of Master of Arts, besides 30 who received certificates for having completed satisfactorily the course on physical culture. A long procession of alumnae in costume marched into the chapel and out again, as there was no place for them to sit. An erudite and beautiful address

was made by the Hon. Curtis Guild, formerly Governor of Massachusetts, in which he spoke of the song "Maryland, My Maryland," to the music of which thousands of young men valiantly rushed into battle and willingly gave up their lives, as a modern adaptation of a medieval melody. One of the most pleasant episodes of my visit to Wellesley was a luncheon at the palatial home of Dr. and Mrs. William Hewson Baltzell, about a mile from the college grounds. Dr. Baltzell is one of our graduates of the class of 1889, who was one of the first resident surgeons of the Hopkins Hospital. He has married a charming Northern lady, and has permanently domiciled near Wellesley.

After the commencement was over myself and party went into Boston, and from there visited a number of historic places that I have always wished to see, and which almost constituted a patriotic duty. The first of these was Plymouth, the scene of the landing of the Pilgrims in 1620. Everyone has heard of Plymouth Rock and the Pilgrims, and New England has been faithful in preserving and transmitting the records of these bold pioneers who landed from the Mayflower on December 26, 1620. Not so well known, especially in the North, is the fact that the cavaliers landed on Jamestown Island, Va., in 1607, and there established the first permanent English colony in America. However, the Pilgrims deserve all the credit they have received, though not more so than their Southern brethren. The visit to Plymouth was especially interesting to me, on account of the conspicuous part taken in the founding of the colony by Edward Winslow and his brother, from one of whom I have no doubt that I am descended. In the museum here are preserved many of the possessions of these early Winslows, as well as those of other members of the colony. The identical rock upon which, according to tradition they first landed, is an erratic boulder left in its present situation by some iceberg and now protected by a canopy and railing. The shore line has been changed by filling in, so that the "Rock" no longer rests in water, but upon dry land. The trip from Boston can be made by steamboat in about three hours, and is a most enjoyable ride upon a pleasant day, or it may be accomplished by trolley if one prefers.

The trolley system of Boston is most complete and extensive; not only is there an abundance of surface lines, but of underground and elevated lines as well. These various roads lead into the

country in various directions and for variable distances. Thus one can travel to Maine by trolley or to New York city. The various towns and cities lying within a comparatively short distance from Boston can all be reached by this means. Lexington and Concord are readily reached in this manner at a cost of a few cents. It is customary to mark the beginning of the Revolutionary War from the skirmish between the British regulars and the Minute Men on the village green at Lexington. Paul Revere, who observed the signal displayed from the old North Church in Boston, rode on the night of April 18, 1775, along the road the trolley now follows and aroused the sleeping Patriots with the news that the regulars were coming. The Minute Men hastily gathered, and the Lexington company, about 50 strong, was drawn up on the commons when the overwhelming British columns arrived. Captain Parker, who commanded this small band of Patriots, gave the following order: "Stand your ground. Don't fire unless fired upon, but if they mean to have a war, let it begin here." In the mêlée 10 of the Minute Men were killed, and some of the British were wounded. From here the regulars made a rapid march to Concord, eight miles away, but they found the whole countryside alive with armed men, and at the old North Bridge effective resistance was encountered, and a retreat began which developed into a rout, as from behind fences and trees and buildings a rain of shot was poured into the fleeing battalions. At Concord "was fired the shot that was heard around the world." To the great credit of New England, commemorative tablets and monuments preserve to posterity the exact locations of these stirring events.

A ride in another direction takes one along the north coast, through Lynn to Salem. Salem is one of the most historic towns in New England. Founded only six years later than Plymouth, it rapidly became one of the most important towns in the colony. Even to this day Salem preserves many of its early characteristics, and its narrow streets and many-gabled and strange-looking houses make it an extremely picturesque and interesting place. Here the witchcraft delusions broke out in 1692 and about 20 persons were put to death and many others imprisoned and otherwise maltreated. The "Witch House," in which Judge Corwin, who was one of the judges of the witchcraft court, lived, is one still standing and in excellent preservation. The beautiful land-locked

harbor of Salem was at one time the rendezvous for a large fleet of merchant ships which traversed all known seas, and carried a large commerce to all parts of the world. Now, alas! the harbor is deserted, and the wharves are practically unoccupied. It was here that Nathaniel Hawthorne was born and lived, and wrote his charming stories "The House of the Seven Gables," "The Scarlet Letter" and others. "The house of the seven gables" is still in existence, and whether it is the identical house described by Hawthorne or not, it certainly has seven gables, and Hawthorne was a frequent visitor to it, and was thoroughly familiar with it. Marblehead is a short trolley ride from Salem; in fact, the tower of a church in Marblehead can be seen from Salem. This is also a quaint place, with old-fashioned houses and narrow streets, and is also situated on a safe land-locked harbor, now mostly filled with private yachts and small fishing craft. It is here that Whittier laid the scene of his poem "Skipper Ireson's Ride."

"Of all the rides since the birth of time,  
Told in story or sung in rhyme—

\* \* \*

The strangest ride that ever was sped  
Was Ireson's, out from Marblehead.  
Old Floyd Ireson, for his hard heart,  
Tarred and feathered and carried in a cart  
By the women of Marblehead.

\* \* \*

Small pity for him! He sailed away  
From a leaking ship in Chaleur Bay—  
Sailed away from a sinking wreck  
With his own town's people on her deck!  
'Lay by! Lay by!' they called to him;  
Back he answered, 'Sink or swim!  
Brag of your catch of fish again!'  
And off he sailed through the fog and rain!"

—Randolph Winslow.

Dr. Henry W. Wickes, class of 1892, passed assistant surgeon, U. S. P. H. & M. H. S., has been directed to proceed to Washington and report to chairman of Board of Medical Examiners to determine his fitness for promotion to the grade of surgeon.

## ABSTRACT

### PELLAGRA.

At the seventh annual conference of State and Territorial health officers with the United States Public Health and Marine Hospital Service, held at Washington, June 2, 1909, Dr. Charles Frederick Williams, class of 1899, and secretary of the South Carolina State Board of Health and State Health Officer, made the following remarks in regards to pellagra:

I think this disease exists not only in the South, but in every State in the Union. Forty-five years ago two cases of probable pellagra were reported at the annual meeting of American Asylum Physicians, held in Washington, D. C., by Doctor Gray of Utica, N. Y., and Doctor Tyler of Somerville, Mass.

Exclusive of one case reported by Dr. H. F. Harris of Georgia, and one by Dr. S. Sherwell of Chicago, in 1902, the disease has since 1864 till recently—1906-7—either disappeared or been overlooked; or, what is more likely, the physician when first studying one of these puzzling cases and inclining to the diagnosis of pellagra, has accepted too readily the assertion of all authorities that pellagra does not exist in the United States, and has therefore given another and commoner name to his case, although his professional conscience may never have been satisfied.

In spite of authoritative denial of the existence of pellagra in our country, a number of cases of the disease were recognized and reported in 1907 independently by medical officers of Alabama and South Carolina asylums. Following these observations, pellagra has been observed in many different localities, such as Wilmington, N. C.; Augusta, Ga.; Charlotte, N. C.; Milledgeville and Atlanta, Ga., and in many places in South Carolina as well as in other States.

For the last year and a half the South Carolina State Board of Health has been actively investigating the pellagra problem by special inquiry, conference and original research, with the co-operation of Surgeon-General Wyman of the United States Public Health and Marine Hospital Service, who has assigned Passed Asst. Surg. C. H. Lavinder to Columbia, S. C., and vicinity for this purpose.

Recently an inquiry (see below) about pellagra was addressed to the superintendents of State

## THE HOSPITAL BULLETIN

hospitals for the insane in the United States, and the following table embodies their replies.

To 164 inquiries 120 replies were received, about 20 being in the affirmative.

The table (bottom of page) seems to show that there are records of about 1000 cases of pellagra scattered in 13 States. More than half of these have been reported from asylums or similar institutions. Sporadic or suspected cases have been reported from Texas and Arkansas, as well as from New York.

Dr. E. J. Wood of Wilmington, N. C., has records of 300 cases in the South, 70 of which occurred in North Carolina. It has been estimated that "many hundred" cases exist in Georgia, and Doctor Walker of the State Sanitarium, Milledgeville, says that 2 per cent. of over 947 admissions in 1908 were pellagra.

Doctor Lavinder has reported to the surgeon-general of his service a conservative estimate of 1500 cases in the Southern States since 1905.

The asylum officers in Maryland have not observed cases, but Dr. W. S. Thayer of the Johns Hopkins Hospital has recently recognized and reported a case of the disease in Baltimore, and is satisfied that he observed a similar case several years ago (1905).

Nor does the disease seem to have appeared in the Tennessee Hospital for the Insane, but 11

cases of pellagra have been reported as occurring in the Baptist Orphans' Home at Nashville.

Doctor Dewing of the Long Island State Hospital, Flatbush, Brooklyn, N. Y., reports that he has had no cases of pellagra in his hospital, but "a few cases apparently from other sections of the country" have been observed in his vicinity.

Dr. C. H. Lavinder observed in New York in 1908 a case of the disease in a white American seaman in the coastwise service.

Although not within the boundaries of the United States, it deserves passing note that Dr. B. K. Ashford has reported the observation of one case in Porto Rico, and Dr. J. A. Hayne has observed two cases on the Panama Canal Zone.

While absolute accuracy is not claimed for these statistics, they may be regarded as a fair indication of the extent and distribution of pellagra, as now recognized in our country, and their presentation at this time is made for the purpose of emphasizing the growing importance of the pellagra problem in the United States.

## DOCTOR WILLIAMS' INTERROGATIONS.

1. Have you seen any case of pellagra in your institution or in your State?
2. How many cases have you seen?
3. How long since you recognized the disease?
4. If at all, how long do you think the disease has existed in your section?

State.	Number.	Recognized.	Probably existed.	Male.	Female.
New York.....	Few (near Brooklyn).....				
Pennsylvania (Dixmont).....	One.....	1909.....		One <sup>a</sup> .....	
Maryland.....	One or two.....	1909.....	1905.....	One.....	One.
Virginia (Staunton).....	One (?).....	1908.....			
Virginia (Petersburg).....	do.....				
North Carolina :					
Raleigh.....	"Several".....		Two or three years.....	Ten years.....	
Goldsboro.....	Eight.....	1908.....	do.....		Eight.
Doctor Taylor, Morganton.....	do.....		Twenty-two years.....		
Doctor McCampbell, Morganton.....	Twenty.....		Five years.....		
Doctor Wood, Wilmington.....	Seventy in State.....				
South Carolina :					
State Hospital.....	One hundred and twenty-five.....	1907.....	Twenty to thirty years.....	Twenty-five per cent.....	Seventy-five per cent.
Doctor Williams, Columbia.....	Five hundred estimated in State.....				
Georgia :					
Grady Hospital, Atlanta.....	Ten.....	1907.....	About twenty-five years.....	Twenty-five per cent.....	Seventy-five per cent.
State Sanitarium, Milledgeville.....	Two hundred and twenty-five.....	1907.....			
Florida (State Hospital, Chattahoochee).....	Twelve.....	1907.....	Four years.....	Five.....	Seven.
Alabama (Mount Vernon Hospital)....	One hundred and fifty-four and two private <sup>b</sup> .....	1906.....		Small number.....	Large number.
Mississippi :					
Jackson.....	One; other cases in State.....				
Meridian.....	Two.....	1907 (?).....		One.....	One.
Louisiana (Pineville).....	Three.....				
Tennessee (Baptist Orphans' Home, Nashville).....	Eleven.....				
Kansas :					
Topeka.....	Six (?).....		Fifteen years.....	Three.....	Three.
Epileptic Colony, Parsons.....	One.....				

<sup>a</sup>Dr. G. H. Searey estimates 150 to 200 cases in State in 1906.

<sup>b</sup>Hungarian.

5. What proportion were male? Female?
6. What was the occupation of those afflicted? Nationality?

7. Do the products of Indian corn (hominy or meal) form a part of the dietary of the patients, and are those products derived from native or shipped corn?

8. Were your patients from the poor, moderate or well-to-do classes, and were they from the city, town or country?

**NOTE.**—There seems little doubt that the condition now recognized as pellagra has existed in the Southern States many years, twenty-five or thirty at least, and has been regarded as an unusual manifestation of tuberculosis, syphilis, malaria, hookworms, dermatitis exfoliativa, eczema, etc.

Probably careful search may disclose that cases of pellagra have been reported under these or other diagnoses.

PRESIDENT PRITCHETT'S LETTER TO  
DR. COALE.

April 4, 1910.

*My Dear Dr. Coale:*

As you know, the Carnegie Foundation has been making a study of medical education in the United States and Canada. In the course of this study every medical school has been visited and a description of its facilities for teaching and study has been prepared. The enclosed statement shows the report which has been prepared concerning the medical department of the University of Maryland. I shall be very glad to have you read this report and return it promptly with any comments you may care to make. It is the wish of the Foundation to have all such reports above all things fair and accurate.

I am, very sincerely yours,

HENRY S. PRITCHETT.

DR. R. DORSEY COALE,

Medical Department

University of Maryland.

STATEMENT.

(3) University of Maryland School of Medicine. Organized 1807. An independent institution, though nominally the medical department of St. John's College (Annapolis).

**Entrance Requirement.**—Less than high school education.

**Attendance.**—316.

**Teaching Staff.**—61, of whom 24 are professors, 37 of other grade.

Resources available for maintenance fees, amounting to \$35,570, out of which dividends are paid to the faculty and a large mortgage debt carried.

**Laboratory Facilities.**—Good undergraduate laboratories, adequate to routine teaching, are provided in two poorly kept buildings for the following subjects: Chemistry, physiology, including physiological chemistry and histology, pathology and bacteriology. Anatomy is poor. No animals were in evidence. There is a small museum in which the specimens are not labeled. In a separate building is a large and interesting library, but it is unheated.

**Clinical Facilities.**—The school controls its own hospital, opposite the laboratory buildings, about 120 beds being available for teaching. The hospital records are well kept, senior students who pay for the privilege serving as clinical assistants. A separate maternity ward furnishes obstetrical work in abundance. The dispensary is large, properly equipped and well-kept.

*Date of Visit.*—March, 1909.

DR. COALE'S COMMENTS UPON THE REPORT OF THE  
CARNEGIE FOUNDATION RELATIVE TO THE  
SCHOOL OF MEDICINE OF THE  
UNIVERSITY OF MARYLAND.

1. University of Maryland School of Medicine, organized 1807. An independent institution, though nominally the Medical Department of St. John's College (Annapolis).

This statement is entirely inaccurate, and, in this connection, I also feel compelled to take exception to the following statement contained in the article entitled, "The Obligation of the University to Medical Education," published in the *Journal of the A. M. A.* for April 2, last, viz.: " \* \* \* such institutions as \* \* \* the University of Maryland, and the like in which the university is really fictitious."

In 1807 a medical college was chartered by the Legislature of Maryland under the title of "The College of Medicine of Maryland." This institution, originally as its name implies, a medical college simply, afterwards became the School of Medicine of the University of Maryland in the following manner:

In 1812 a second act was passed by the Legislature adding to the already existing "College of

Medicine of Maryland," "the three other colleges or faculties, viz., The Faculty of Divinity, The Faculty of Law, and The Faculty of the Arts and Sciences, and the four colleges or faculties shall be and are hereby constituted an university, by the name and under the title of The University of Maryland."

The act further establishes a governing body for the university to be entitled "The Regents of the University of Maryland," declares said regents to be "one corporation and body politic, to have continuance forever," authorizes the appointment by the regents of the proper officers of the university, the granting of the usual degrees, etc., etc.

This is the charter under which the University of Maryland is now operating.

The Faculty of Physic has been in continuous and uninterrupted operation since its foundation in 1807; the present Departments of Dentistry and of Pharmacy are departments of this faculty. The Faculty of Law has been in continuous operation for the past forty years, though suffering some interruption prior to that time.

The Faculty of Divinity was never organized further than by the appointment by the regents of a professor of Theology. The Faculty of the Arts and Sciences was organized and was in operation until about the close of the Civil War, when it discontinued its work.

In order to re-create this department of the university, some three years ago, a formal agreement or contract was entered into between the regents of the University of Maryland and the governing body of St. John's College, whereby St. John's College became the Department of Arts and Sciences of the University of Maryland.

This agreement or contract is, I understand, similar to that existing between some of the component institutions of the Northwestern University, and was modeled upon them.

At the yearly commencement held in Baltimore, degrees are conferred by and under the authority of the *Regents of the University of Maryland* upon students who have completed the prescribed courses in St. John's College, as well as in the different professional schools of the university.

The School of Medicine of the University of Maryland can not, therefore, in any sense, nominally or otherwise, be said to be the "medical department of St. John's College;" nor does it appear to me that an institution now, and for years

past, in active operation under a university charter nearly one hundred years old, and attended by an aggregate of over one thousand students in its various departments, can fairly be termed "fictitious."

2. Entrance requirement. Less than high school education.

It has been our sincere desire and intention to strictly enforce the admission requirements of the Association of American Medical Colleges, and we have always believed that we had done so. This standard having been called in question, however, we have, in connection with the other association schools in this city, recently entered into an arrangement with Dr. A. S. Downing, First Assistant Commissioner of Education of New York, which will, I think, insure in future the maintenance of the standard of admission requirement adopted by our examiner in this city as equal to that of the education department of New York.

3. Resources available for maintenance. Fees, amounting to \$35.570, out of which dividends are paid, etc.

I cannot reconcile these figures with my own. For the fiscal year 1907-08, from which, I presume, the above statement was taken, the fees and receipts available for the maintenance of the School of Medicine were as follows:

Matriculation fees.....	\$1,570 00
House fees.....	4,870 00
Tuition fees.....	28,995 50
Practical anatomy fees.....	750 00
Graduation fees.....	2,190 00
Rents.....	2,155 14
State appropriation.....	4,000 00
<hr/>	
Total.....	\$44,530 64

This may be taken as an average year, although the receipts for the following year (1908-09) amounted to \$50,279.30—more than \$5700 more. For the previous year (1906-07) the receipts amounted to \$43,765.21.

This amount is that available for the maintenance of the School of Medicine exclusively. It has no connection whatever with the receipts of any other School or Department of the University, nor with those of the University Hospital.

While the University Hospital is the property of the Faculty of Physic, and conducted by this Faculty, and may be regarded as an essential part of the School of Medicine, its financial accounts

are kept entirely separate from those of the medical school proper. The receipts of the hospital amount to \$70,000 yearly. We also have a small, but growing, endowment fund.

#### 4. Anatomy is poor.

As no reasons are given for this statement, it is somewhat difficult to comment upon it. I would say, however, that we have a large, well-lighted and well-ventilated dissecting room, and that dissecting material is supplied in abundance, an average of seventy cadavers being used yearly. A disarticulated skeleton is supplied to each student for use in study during his course in anatomy.

The department is fully supplied with charts and diagrams, and with an exceptionally large number of preparations of all kinds, both wet and dry, the accumulation of a hundred years, many of which are of great value and some absolutely unique in this country. There are eight instructors in the department—one professor, one associate professor and demonstrator, four assistant demonstrators and two instructors. Students are thoroughly taught and strictly examined.

We have always believed that our teaching of anatomy and facilities for such teaching were exceptionally good.

#### 5. No animals were in evidence.

An ample supply of frogs, terrapin, etc., is constantly kept on hand. Students are not, however, permitted to perform physiologic demonstrations upon living warm-blooded animals, but such demonstrations are frequently made before them by competent instructors.

#### 6. There is a small museum in which the specimens are not labeled.

There is evidently some misunderstanding here. The museum of the School of Medicine contains over 400 specimens, carefully labeled and catalogued, many of which are very valuable. About three months after Mr. Flexner's visit to the institution, an exhibit selected from this museum received a Certificate of Honor from the American Medical Association at the annual meeting of the Association in Atlantic City.

There is, in another room, a smaller collection of specimens of *materia medica* and pharmacy, anatomical dissections, bones, specimens of various fractures, etc., etc., which are used as working specimens for illustration in teaching. I am

inclined to think that it must be this collection which is referred to.

#### 7. Library was unheated.

This is an exceptional and accidental circumstance. Mr. Flexner's visit was made upon the morning of Friday, March 5, 1909, immediately after the great blizzard of the 3d and 4th insts. and the most severe weather of the winter. Furthermore, the previous day had been a holiday (Inauguration Day), and the university buildings had been closed. There had, I presume, not been sufficient time for the hall to become properly warmed, but it is usually kept at a comfortable temperature.

#### 8. About 120 beds available for teaching.

The University Hospital contains 260 beds, including those for obstetrical cases, which now occupy wards in the hospital opened since Mr. Flexner's visit.

All of these beds are, in a sense, available for and used in teaching. The number of beds in the free wards, exclusive of the obstetrical wards available for ward classes and clinical instruction of the class, generally is 140.

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#### ABRAHAM FLEXNER'S LETTER TO DR. R. DORSEY COALE.

April 20, 1910.

*Dear Dr. Coale:*

Please accept our thanks for your letters of April 18 to President Pritchett and to myself. The report sent you will be worked over carefully in the light of the statements which you make. We appreciate very highly your courteous attitude in this matter.

I think, perhaps, that you have misunderstood President Pritchett's address in so far as it deals with the conception of a university. It is not, of course, a question as to how a charter reads. A university is not made by its articles of incorporation. It is a question of its ideals, activities, organization, government and so forth. The main trunk, out of which the professional schools of a university grow, is its academic department: so that in using the term in a real sense, there can be no university which a faculty of arts does not precede and dominate. If, for example, you will compare the relations of your professional schools to each other and to St. John's College with the conditions that prevail in the Johns Hopkins, in your own city, you will, I think, appreciate the distinction which we have tried to make

between a nominal and an actual university. A consolidation of medical departments in Baltimore, in the hands of the Johns Hopkins University, with the utter wiping out of the few wretched schools there which I need not mention by name, would, it seems to us, be greatly to the profit of medical education and to the credit of the City of Baltimore.

I am, with best wishes and warm regards,

Very sincerely yours,

ABRAHAM FLEXNER.

DR. R. DORSEY COALE,

Dean of the Faculty of Physic  
University of Maryland.

### ITEMS

Dr. Page Edmunds, class of 1898, is spending the month of August at Ocean City.

Dr. James M. Craighill, class of 1882, will spend August and September at Murray Bay, Canada.

Dr. Lewis C. Carrico, class of 1885, of Bryantown, Charles County, Md., is being urged by his friends as a Democratic Congressional candidate in the Fifth district. Doctor Carrico represented Charles county in the House of Delegates of Maryland in 1892, and in 1893 was elected to the Senate over Congressman Sydney E. Mudd. His record in both branches of the State Legislature was such as to win a large following for him in the counties of Southern Maryland, and especially in Charles county, where he is held in high esteem. He is a large landowner and enjoys an extensive medical practice, and besides is connected with many business enterprises in the county, including the Hughesville Bank, of which he is a director.

Dr. Alexander D. McConachie, class of 1890, is spending August motoring through Maine and Canada.

Dr. James A. Nydegger, class of 1892, surgeon, U. S. P. H. & M. H. S., was granted seven days sick leave in July.

Dr. William Newbold Bispham, class of 1897, captain, U. S. A., was granted twenty days leave of absence in July.

The editors of THE BULLETIN are endeavoring to complete several sets of THE BULLETIN for various libraries. The following numbers are desired:

June, July, August, October and December, 1905; March, June and July, 1906; January, July and December, 1907; March, 1908; April, February, June, November and December, 1909; January, February and March, 1910.

Anybody having the same and willing to part with them will be conferring a great favor upon us by notifying the office to that effect.

The members of the Baltimore County Medical Association were the guests of Dr. George C. McCormick, class of 1890, and Dr. Frank C. Eldred, class of 1891, at Sparrows Point, July 21, 1910.

A meeting of the citizens of Havre de Grace was called by the Board of Trade for August 11 to discuss the advisability of erecting a hospital. Dr. J. Lee Hopkins, class of 1897, was secretary of the meeting. So many influential citizens are back of the movement that there is little doubt but that the hospital will be erected.

The following members of the class of 1910 successfully passed the State Board of Medical Examiners of Maryland:

George S. Condit, George Cookman Coulbourn, Clifton Norwood DeVilbiss, Roland R. Diller, Frank Paul Fiery, Max Joseph Fiery, Cyril Elmo Fowble, William Anderson Gracie, Maxey Gregg Hoffman, Norman Thomas Kirk, Erasmus H. Kloman, John Moody Blodgett, Adolphus L. Little, Michael J. McDermott, Vernon Hastings McKnight, John E. O'Neill, Maurice E. B. Owens, Dwight Gray Rivers, Louis Rubin, John G. Runkel, Napoleon Bryan Steward, George L. Stickney, James Edward Talbott, Ralph C. P. Truitt, John Henry Von Dreele, Jr., George Walter, and also Joseph W. Ricketts, class of 1909.

Dr. Alexander D. McConachie, class of 1890, talked on the fight against tuberculosis at the last meeting of the Queen Anne's County Medical Society, held at Centerville, July 20.

Dr. Charles Teackle Buckner, class of 1899, will leave for a visit to North Hatley, Canada, on August 20.

Dr. Frank Martin, class of 1886, will spend the remainder of the summer at the New Profile House, White Mountains, N. H.

The Baltimore county sanitary officers were entertained by Dr. J. F. H. Gorsuch, class of 1876, of Fork, Md., at his offices in the Masonic Temple, Towson, July 29.

Dr. H. P. Gibson, a former student, class of 1907, after successfully passing the State Board, has permanently located with his brother, Dr. John A. Gibson, class of 1901, at Leesburg, Virginia.

Dr. O. Edward Janney, class of 1881, was a delegate to the "white slave" conference, held at Mountain Lake Park, July 21. He read a paper on "Methods for the Suppression and Prevention of the Traffic in Women." He has since gone to Ocean Grove, N. J.

Dr. Albert H. Carroll, class of 1906, is traveling in Nova Scotia, Newfoundland and Greenland.

Dr. Henry Chandlee, class of 1882, has gone to his summer camp in Canada.

It has been suggested that the Holyrood tract of land be named Venable Park in honor of the late Major Richard M. Venable, a regent of the University of Maryland.

Dr. William Frank Lucas, class of 1893, is a guest at the Rio Grande, Atlantic City.

Dr. Harry C. Hyde, class of 1899, has returned from a visit to Buffalo, Niagara Falls and Cleveland.

Dr. Marshall Smith, class of 1887, is spending August at Blue Ridge Summit, Pa.

Dr. Frank J. Kirby, class of 1892, is spending August in Canada.

Dr. John Turner, class of 1892, is in Venice, Italy.

Dr. Latimer Rudolph, class of 1902, is located at Gainesville, Ga.

A graduate of the University of Maryland, class of 1909, received the highest average at the April examination of the Minnesota State Board of Medical Examiners, attaining an average of 91.2.

All of the officers of the Dorchester County Medical Society for the ensuing year are University of Maryland men. They are as follows: Dr. Victor C. Carroll of Cambridge, class of 1906, president; Dr. C. F. Maguire of Hurlock, class of 1883, vice-president; Dr. W. H. Houston of Fishing Creek, class of 1900, secretary-treasurer, and Dr. Benjamin L. Smith of Madison, class of 1859, delegate.

Dr. J. Fred Adams, class of 1894, is spending the summer at Catonsville.

Dr. C. Urban Smith has returned from a motoring trip through Maryland and Pennsylvania.

Dr. St. Clair Spruill, class of 1890, has returned to Baltimore after four weeks spent in the North. After some very exciting trout fishing at Twin Lakes, in Northern Pennsylvania, he went to New York, and later spent two weeks at Atlantic City.

Dr. George A. Fleming, class of 1894, has returned from an automobile trip through the Shenandoah Valley and the mountains of Virginia.

Dr. Julian Mason Gillespie, class of 1909, has been commissioned as assistant surgeon in the Public Health and Marine Hospital Service, and ordered to the Marine Hospital at Honolulu.

Dr. Hiram Woods, class of 1882, is spending six weeks at Blue Ridge Summit.

Dr. B. Merrill Hopkinson, class of 1885, is spending the summer at Haven, Maine.

Dr. Charles E. Sadtler, class of 1873, sailed for Germany August 3, by the North German Lloyd, and will return to Baltimore the latter part of September.

Plans for a two-story cottage, to be attached to the men's group at Springfield State Hospital for the Insane, Dr. J. Clement Clarke, class of 1880, superintendent, have been approved by the managers of the institution, and the erection will begin immediately.

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Dr. Harry Dorsey Purdum, class of 1902, formerly of the Northern Michigan Asylum, Traverse City, Mich., has removed to Baltimore, where he has accepted the position of chief resident physician of Bayview Asylum, Insane Department.

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Dr. Frank W. Weed, class of 1903, captain, U. S. A., has been assigned to duty as inspector-instructor, Medical and Hospital Corps, Fourth New Jersey Infantry, at Sea Girt, N. J., from August 1 to August 6.

## MARRIAGES

Dr. John Bushrod Schwatka, class of 1882, was married to Miss Nina M. Duvall at St. Luke's Protestant Episcopal Church, July 29, 1910. The couple will spend several months in Europe, after which they will reside at 1003 North Broadway. Dr. Schwatka is a native of Chestertown, Md., and received his primary education at the Academy of Sudlersville. After his graduation at the University of Maryland in 1882 he spent one year practicing in Delaware, after which he located in Baltimore, where he has since remained. He was president of the Baltimore Medical and Surgical Society, 1897-98, and has been an assistant surgeon to the Fourth Regiment, M. N. G., since 1896. He was Sheriff of Baltimore for two years, 1899-1901. He has been in turn demonstrator and lecturer on anatomy at the Baltimore Medical College, and professor of diseases of children and clinical medicine and professor of gross pathology at the Maryland Medical College. He is well known, and enjoys a large practice in Baltimore.

## DEATHS

Doctor Kenneth A. Blue, class of 1889, died at his home in Laurinburg, North Carolina, July 16, 1910, from nephritis, aged 43 years. Doctor Blue was a member of the Medical Society of the State of North Carolina.

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Doctor Frank Camm, class of 1885, died at his

home in Lynchburg, Virginia, July 28, 1910, aged 62 years. He had been in failing health for some time. During the Spanish-American war Dr. Camm was a surgeon at Camp Alger, Virginia. He was unmarried.

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On August 4, 1910, Mary Belinda, infant daughter of Doctor Harry M. Slade, class of 1884, died at the home of her parents at Reisters-town, Maryland.

## BOOK REVIEW

**HOOKWORM DISEASE.** By George Dock, A.M., M.D., Professor of the Theory and Practice of Medicine, Medical Department of Tulane University of Louisiana, New Orleans, and Charles C. Bass, M.D., Instructor of Clinical Microscopy and Clinical Medicine, Medical Department of Tulane University of Louisiana, New Orleans. Illustrated with 49 special engravings and colored plates. St. Louis: C. V. Mosby Co. 1910. Cloth, \$2.00.

Though this malady must have been prevalent for many years in the United States, it was not until the last years of the nineteenth century physicians became alive to the fact that it was widely distributed throughout the country and was the cause of much ill-defined sickness and a great economic loss in service of those affected. Since Stiles discovered a new species of ankylostomia in man, much progress has been made in our knowledge of this dreadful scourge, and it is to bring this information into a practical readable form that Doctors Dock and Bass felt constrained to present this monograph to the medical profession. The history of the disease, so far as it is possible to trace it, the zoology of the hookworm, both the old world and the new world varieties, its distribution, modes of infection, etiology, pathology, diagnosis, prophylaxis and treatment, have been brought together into such a form as to be available, and in such language as to be easily understood by the general practitioner. The book is freely illustrated, well printed and written in such a clear, concise style that even the general public could read it understandingly. Both the publishers and the authors are to be congratulated on the timeliness and excellence of their publication.

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## SHOCK, FAT EMBOLISM AND AIR EMBOLISM.

*Abstract of Lecture Delivered at the University of Maryland by Randolph Winslow, M.D., LL.D., Professor of Surgery, University of Maryland.*

### SHOCK.

**Definition.**—Shock may be defined as a condition of depression of the vital functions due to vaso-motor paralysis, resulting from mechanical injury or mental impressions.

"Surgical shock is mainly due to impairment or break down of the vaso-motor mechanism." (Crile.)

Injuries to certain parts of the body are especially liable to be followed by a condition of shock, such as traumatism of the vagal area, the region of distribution of the superior laryngeal nerve, the splanchnic area, in fact, of all those parts richly supplied with nerves. In shock there is a distention of the deep vessels, consequently such an anemia of the peripheral tissues ensues as practically to amount to hemorrhage.

**Causes of Shock.**—The causes of shock are both predisposing and exciting. Among the predisposing causes may be mentioned diseased conditions of the vital organs, especially the kidneys and heart, debility, fear, pain, idiosyncrasy and age. The most prominent exciting causes producing shock are injuries, especially crushing traumatisms, surgical operations, anesthetics, pain, fear, temperature. Mental shock, as of fright, may at once prove fatal; even joy has been known to terminate disastrously. Shock is usually due to injury, or supervenes during surgical operations. The degree of shock depends much upon the mental condition of the patient. In some cases a very slight traumatism is followed by marked shock; in others a fatal injury may not be indicated by shock at all, as where a soldier in the heat of battle receives a serious wound.

Injury to the abdominal viscera is usually followed by much depression, due to the impression on the splanchnic nerves, causing a vaso-motor paralysis and a distention of the great veins of the abdomen. Sometimes it is due to cardiac inhibition through the pneumogastric nerve, as by a blow on the epigastrium or in the neck.

**Symptoms.**—The first indication of shock is usually found in the pulse, which is weak, rapid, small, compressible, as not enough blood is supplied to the heart; the respiration is shallow and irregular; the cutaneous and mucous surfaces are pale or bluish; the skin is cool and the temperature subnormal; the integument moist or sweating; the features pinched and the countenance anxious; the patient may be in a semi-conscious condition; frequently there is vomiting, as well as relaxation of the sphincters; the pupils are dilated and react poorly to light. There may be suppression of urine, and late vomiting is a bad sign. Delirium, if present, is an unfavorable symptom. In favorable cases these symptoms gradually subside, the skin becomes warm and dry, the pulse and temperature regain their tone and become more nearly normal, and the patient recovers; or the symptoms continue to become more grave, the pulse fails and does not rally, unconsciousness supervenes, and the patient dies. Shock may be dependent on loss of blood, and it is sometimes difficult to distinguish between the symptoms of concealed hemorrhage and those of shock. In shock the hemoglobin is unaffected, whilst it is markedly lowered in hemorrhage. Shock comes on earlier than fat embolism.

**Prevention of Shock.**—Examine the patient carefully, wrap him in blankets; before the operation give morphia and atropia hypodermically to steady the heart, and lessen the effect of the anesthetic. We may give a hot salt enema or infusion just prior to the operation, use hot water bags to the body, or an operating table in which hot water pipes are placed; block the nerves with cocaine in some cases.

**Treatment.**—If the patient is still on the opera-

ting table, hurry the operation, lower the head, give salt infusions, strychnia and digitalin, or 20 minimis of a one per cent. solution of adrenalin chloride hypodermically, or nitrate of amyl inhalations. In some cases the limbs may be bandaged to force the blood into the body and brain, and hypodermic injections of ether may be given. A hot black coffee enema often does good service. When the patient is put to bed he should be placed in the recumbent position and the foot of the bed should be elevated; hot water bags or bottles should be placed in the bed, but not next to the skin of the patient, or warm cans or bricks wrapped in cloths, in order to favor a return of the circulation. If the patient is restless morphia may be given hypodermically, to insure quiet and rest. Strychnia and digitalin may be given for the weak pulse. Camphorated oil in 15 to 20 minim doses may be administered hypodermically in many cases with excellent results. Be careful not to burn these depressed patients with hot water bags or cans, as they are usually unconscious and may not feel the heat until severe injuries have been inflicted.

#### FAT EMBOLISM.

As the result of crushing injuries, and especially of injuries to the long bones, fat is set free in the tissues and is frequently absorbed and conveyed by the blood vessels to the lungs, where the oil globules obstruct the pulmonary capillaries, causing symptoms of edema of the lungs. If the amount of fat absorbed is small it may become oxidized in the lungs and the dangerous symptoms pass off, or the oil globules may pass through the pulmonary vessels and finally reach the terminal vessels of the brain and obstruct these, causing symptoms of cerebral embolism. Whilst fat embolism is more apt to occur in obese individuals, it may occur in others, and doubtless occurs more frequently than it is recognized. In fact, it is probable that some cases of unexpected and unexplained deaths are the result of this cause.

*Symptoms.*—The symptoms are very similar to those of shock, or of edema of the lungs. If after an operation or traumatism the symptoms of shock supervene, with rapid respiration, cyanosis, and symptoms referable to interference with the lungs, we may suspect fat embolism. If particles of oil are found in the urine, which have not been introduced on a catheter or in some accidental way, the diagnosis is clear. When the oil globules pass through the lungs and become lodged

in the brain, the symptoms will vary with the location of the emboli. Fat embolism occurs in from 24 to 48 hours after injury, and in this manner may be differentiated from shock, which comes on at the time of injury. Where the amount of oil conveyed to the lungs is small, absorption may occur and the serious symptoms pass off; or the pulse may become more rapid and weaker, the respirations more frequent and embarrassed, and death supervene.

*Treatment.*—Stimulate the patient freely with whiskey, strychnia or digitalin. Keep in the recumbent position. Inhalations of oxygen may also be used.

#### AIR EMBOLISM.

This is a rare condition, but one that is liable to occur as a result of injury to the large veins, and especially to those of the neck, which may be held open when cut, by the arrangement of the fascia of this part. The accident has occurred from injury to the smaller veins, as the thyroid, and also in a few instances when the more remote vessels, as the femoral or axillary, have been cut. By air embolism is meant the aspiration of the air through the cut or torn end of a vein, which is usually at once known by the hissing sound, due to the entrance of the air into the vein. The air soon reaches the heart and causes a foamy condition of the blood, which it may be impossible for the heart to propel into the lungs. Generally there is at once an irregular heart's action, the pulse becomes small and rapid, respiration accelerated, cyanosis supervenes, and in some cases death soon follows. In other cases but little untoward effects are noticed. If the amount of air is not large and the heart can propel it to the lungs, the air will be eliminated or absorbed and recovery result. Death is usually due to the fact that no aerated blood is returned to the left ventricle and the circulation ceases. As air aspiration usually occurs during operations at the root of the neck, great care should be taken not to cut or lacerate the veins, and when it becomes necessary to do so first seize them with clamps and apply double ligatures before dividing them.

*Treatment.*—The treatment is to avoid injury if possible. When air enters a vein at once place a finger or a piece of gauze on the vessel or apply a clamp and ligature, or the wound may be filled with water. Stimulate the patient freely. Perform artificial respiration, administer oxygen and keep the patient in the dependent position.

POTT'S DISEASE: ITS SYMPTOMS AND  
DIAGNOSIS.\*

By JAMES G. MATTHEWS, M.D.,  
Spokane, Washington.  
(Class of 1905.)

Pott's disease is a progressive tuberculous lesion involving the vertebral bodies and intervertebral discs.

It is so called from Pott, who was the first to accurately describe it in the year 1779.

The disease was known to Hippocrates as early as 500 B. C., but Delpech and Nélaton, early French investigators, were the first to attribute the disease to tuberculosis.

*Frequency.*—In Beuthner's clinic, out of 78,297 patients, 280 cases were Pott's disease; in Lorenz's, 251 out of 32,424; in Hoffa's, 142 out of 1444 cases of deformity found.

Pott's disease is more prevalent than any other form of joint tuberculosis. The reports of the Children's Hospital in Boston, out of 5950 cases of joint tuberculosis, give 2867 to Pott's disease and 2281 to hip.

*Age.*—It occurs at any age, but is most prevalent between the ages of one and fourteen. Mohr reports 71 per cent.; Drachman, 80 per cent.; Taylor, 84 per cent.; Young, 77 per cent. of Pott's disease as occurring between these ages. Bryant describes a case occurring in a fetus. Marsh reports three cases in patients over sixty.

Sex has little or nothing to do with the occurrence of the disease.

*Heredity.*—Heredity plays a very important etiologic part. Young noted in 416 cases a hereditary tuberculous taint in 24 per cent.; Gibney in 185, 76 per cent.; Lorenz in 251 cases, 25 per cent. The disease is very common in children suffering from scrofula or conditions known as strumous diathesis. Pulmonary tuberculosis is very rare with Pott's disease.

*Pathology.*—The bacilli usually reach the bone by the blood, and by irritation of their toxines cause a proliferation of the connective tissue and endothelial cells which lie in direct contact with the germs, and about these a ring of leucocytes is found, together with one or more giant cells. These elements constitute the visible tubercle which appears as a gray speck. As the tubercle

enlarges the cells undergo a coagulation necrosis as a result of lack of nutrition and pressure. The tubercle changes to a yellow color, the bacilli multiplying and escaping from new tubercles. The surrounding tissue becomes congested, and fixed cells become organized or partly so. If successful, the area is walled off. If not, the process of destruction destroys the barrier and overcomes nature's wall and spreads. This is a progressive tubercular osteitis terminating in interstitial absorption or caries, and affects primarily the cancellous structure of the anterior portion of the body of the vertebra. The steps of spinal caries proceeds as does any other tuberculous osseous lesion, namely, congestion, formation of granulation tissue, degeneration and softening of the tubercle with pus formation, caseation, bone absorption, following each other in slow succession.

The primary lesion is located usually in the body, but may be found in the laminae or arches. There may be one or many foci. The lesion spreads forward to the anterior common vertebral ligament and upward and downward by contiguity. The involvement and destruction of the vertebral bodies makes them unfit for weight-bearing, and they soon collapse under the superincumbent weight, producing the characteristic deformity, the angle of which depends upon the number of vertebrae destroyed. If the disease progresses rapidly, large sequestra are cut off by the areas of granulation, producing the so-called caries necrotica.

Whitman speaks of the small pieces of bone as bone sand.

The intervertebral discs seem to offer some protection against the spread of the infection, but when both sides are involved they are soon destroyed.

Where there is a widespread infection over the anterior portion of the surface of the body, this is spoken of as spondylitis superficialis.

At the collapse of the vertebral bodies, the chest goes forward, carrying the ribs with it, producing a marked deformity and a change in the position of the aorta and the mediastinal viscera.

A compensatory change is usually seen above and below the affected area. Abscesses occur very frequently.

Paraplegia, not uncommon in Pott's, seldom comes from direct pressure of the bone, but commences as a pachymeningitis externus, then extends through the membranes by contiguity. The

\*Read before the Spokane Medical Society.

thickening of the membranes thereby compresses the cord and establishes the compression myelitis, which is usually the cause of paraplegia. Paraplegia may also be due to obliteration of the canal by caseous deposit, sequestra or abscess. The deformity itself is the direct cause in about 2 per cent. of cases.

The violence of the disease having exhausted itself, the process of repair sets in. In fact, long before the acute degeneration has subsided in the bodies, the processes are ankylosed. They are surrounded by a fibrous tissue. The caseous masses are absorbed, encapsulated or calcified. Osteophytes lock together and ankylose the bodies.

*Occurrence.*—The dorsal is the most common region affected. The cervical the least—dorsal, 60 per cent.; lumbar, 30 per cent.; cervical, 10 per cent.

*Prognosis.*—Pott's disease is more fatal in the old than in the young. It is the most dangerous of all tuberculous affections. The cures achieved in modern times may be justly attributed to early diagnosis, and better knowledge of etiology, pathology and progress of disease, together with a skillful adaption of mechanical measures. Much depends upon the severity of the lesion and the general condition of the patient. The most favorable prognosis obtains in the cervical region; least favorable in the dorsal. Generally speaking, 20 to 30 per cent. of all cases die in the first two years. The run-down condition of the patient makes them more susceptible to some intercurrent disease. The surroundings have as much to do with prognosis as the treatment. A good inheritance, fair general condition, early treatment, absence of tuberculous disease in other joints, absence of high fever and excessive pain, offer a favorable, the reverse, an unfavorable prognosis. Nothing is so unfortunate as the formation of an abscess which drains for a long time and has its exit on the surface some distance from the seat of trouble. The constant drain upon the system is a menace to life, as amyloid degeneration often sets in.

Young says when the opening of the abscess is near the seat of disease, the prognosis is better than when no abscess occurs.

*Paraplegia.*—A distressing and alarming complication has a most favorable prognosis. Gibney's, Taylor's and Lovett's reports show cures in 60 to 90 per cent. of cases. You often get relapse of this condition if treatment is discontinued

too soon. Where both sensation and motion are lost, the recovery is only partial.

The spasms and contractions which occur late in the disease are usually permanent. Fatal cases generally die from simple asthenia, hectic pyemia, amyloid degeneration, intercurrent affections, tuberculosis in other parts, or rupture of the abscess internally. Ashurst reports one case where the psoas abscess caused ulceration and rupture of a branch of the internal iliac.

In slight deformity, chance for long life is good; in medium the patients die young of phthisis; in severe they succumb of fatigue and heart failure. Hypertrophy of the heart is common. In cervical cases, without proper support, death may occur as suddenly as in apoplexy.

*Symptomatology.*—In well-advanced cases the diagnosis appears to be easy, but in the early stage it is very difficult. I dare say, some of you have heard of or seen cases where one of our confreres have slipped up, or you yourself may have been so unfortunate. As a rule, the premonitory stage passes unobserved or is called by the indefinite term malaise (the condition existing between perfect health and debilitating sickness). There is an indisposition on the part of the patient to indulge in his play or duty, irritability, loss of activity. This appears to be the calm before the ravage of the disease.

Among the first and most important symptoms is muscular spasm or rigidity of the spine. It is either a reflex act or an automatic unconscious effort of the patient to protect the affected part, and is spoken of at times as reflex tetanoid spasm. There is marked atrophy of the erector spinae muscles.

The attitude assumed depends upon the location of the affection. In the cervical region wry neck is the most characteristic attitude. The child rests his elbows upon the table and supports his head with his two hands. If the lesion is in the cervico-dorsal region, the neck is pushed forward, chin elevated, shoulders drawn up; if in the dorsal region, the spine is curved forward above and below the seat of the disease, the shoulders are elevated, the spine is rigid, giving a military attitude; if standing, the hands are held on the hips, or while sitting the chair is grasped in both hands, thus supporting some of the weight in this manner. The characteristic method or manner they have of supporting the weight on the thighs, in stooping or picking up objects from the

floor without bending their spine, is exceedingly pathognomonic of Pott's disease. If a psoas abscess be present, there will be a slight adduction of the thigh of the side affected, the patient walks on his toes, puts his feet down with great care, avoiding any jar of the vertebrae. Stiffness of the vertebral muscles is most marked. If you attempt to straighten a head in cervical affection, the whole body moves; or if you place a child on the table and elevate the feet in place of the normal bending of the spine, the whole trunk moves en masse.

*Pain.*—Pain, a very misleading symptom, is generally present and of a most distressing type, although a number of cases have been reported without pain. It is usually deep-seated, dull and sub-acute unless a jar of the vertebrae makes it more severe. As a rule it is experienced at the peripheral endings of the irritated nerves, usually at or below the vertebrae involved, except in the cervical region when the patient usually has severe occipital headache. At times the ribs press against each other and cause severe pain, necessitating for its relief a rib resection. Severe abdominal pain is common. Torticollis, neuralgia, bronchitis, pneumonia, cystitis and gastralgia are often treated for this trouble. Night cries are rare. A grunting respiration is common. In one instance a lateral perineal cystotomy was done for removal of supposed stone, and autopsy showed a lumbar caries. Attempts to cure a case of caries, supposed to be torticollis, by forcible correction have caused death. One of the most remarkable cases I have seen was a girl of 20, a picture of health—no tuberculous taint, with a history of an appendectomy six months before. Since then the abdomen has been opened twice for pain in the right side. After watching her for several days, she had no temperature, no muscular rigidity and no stiffness of spine. I came to the conclusion that it was neurasthenia. The surgeons said adhesion and operated, finding nothing. X-ray showed lumbar caries and the case was turned over to the orthopedic side.

*Deformity.*—Posterior angular curvature is the most conspicuous. Where but one or two vertebrae are involved it is sharp. Where many are involved the curve is long and gradual. Angular deformity is frequently absent in the cervical and lumbar regions. Muscular atrophy, due to spasms and contraction and compensatory deformity, come on after the bony deformity.

*Abscess.*—Abscess is not an uncommon com-

pliation. Taylor reports it present in 14 per cent. of his cases. Some reports go as high as 45 per cent.

It is more common in dorsal and lumbar Pott's. It generally begins as a cold abscess, running an apyretic course, but the temperature has been known to rise as high as 105° F. As a rule there are but slight constitutional symptoms. The morning temperature is 98° F., the evening temperature 101° F. These abscesses may gain an enormous size and remain stationary for a long period. They spread in the direction of least resistance, usually following the fascias of muscles.

Cervical abscess usually follows the longus colli or scaleni muscles and points externally posterior to the sterno-cleido-mastoid. Some, however, open on the posterior wall of the pharynx, or burrow into the mediastinum, and may rupture into any of the surrounding parts. Dorsal abscesses usually pass beneath ligamentum arcuatum interitum within the sheath of the psoas magnus and appear externally in Scarpa's triangle.

Lumbar abscesses are so influenced by the arrangement of the fascia, and may appear most any place (glutial, iliac, vaginal or rectal region).

*Diagnosis.*—The importance of early diagnosis cannot be over-estimated. The most thorough examination, both oral and physical, is essential. The oral is difficult, for the parents are never certain. The trouble generally dates from a fall. For them to be able to answer questions such as, when was the child last perfectly well, is almost impossible. After the diagnosis is evident, the family then remember the past history. The diagnosis depends principally upon the physical signs. The mobility and contour of the spine are most important aids to a proper diagnosis. In putting the child through the various motions, let there be a definite reason for each, using tact in bringing out the natural movements, whilst watching for any muscular spasms. This is very evident in the early part of the disease, and is easily demonstrable by having a child pick up something from the floor or elevating the limbs with the child lying on its abdomen. In cases where we have psoas inflammation or abscess, place the child on his back on the edge of a table, and the side not affected will drop down several inches lower than the other. In very young infants there are often severe screams when the child is being moved about, while it is perfectly

comfortable if lying still. The muscles are very rigid. The labored or grunting respiration is almost pathognomonic of Pott's. In dorsal affections, diaphragmatic respiration is common. There is at times an irritating indefinite cough. There is usually some lateral deviation of the spine, pain is present in most cases, paraplegia comes on late, increased reflexes are marked, the X-ray may be of some service, but negative results do not necessitate throwing out of the disease. The Morro, the Calmette and Von Pirquet tests are too sensitive to be of much service. The sub-cutaneous injection of old tuberculin is of more value, keeping a close watch upon the temperature line.

*Differential Diagnosis.*—The kyphosis of Pott's is characterized by its median position and rigidity; so marked are these peculiarities that confusion with lateral curvature is not likely to occur except where we have marked lateral deviation in Pott's. In lateral curvatures there is no pain and no temperature, and muscular atrophy and rigidity are not so marked as in Pott's.

Aneurysms eroding the vertebrae are difficult at times to differentiate from spinal caries, but the localized pain and age aid much in the diagnosis. The same is true in cancerous growths. From sarcoma, typhoid spine, syphilitic and phosphorus necrosis, age and history help much. Time will not permit us to go into minute details.

Rheumatoid arthritis occurs late in life, associated with stiffening and arching of the spine and absence of kyphosis, abscess or muscle spasm.

Vertebral osteomyelitis is recognized by its acute onset, rapid suppuration, rigors, marked febrile alterations, rapid pulse and respiration, diarrhea, extensive destruction of the vertebrae and the leucocytosis which is absent in Pott's disease.

In rachitic spine there are other symptoms of the affliction, and the curves are longer, less regular and more flexible.

The nerve and cord symptoms will usually be associated with marked kyphosis and rigidity of the spine and often abscesses. In the neuro-mimeses, or so-called hysteria of the spine, great difficulty is encountered, especially hysterical paraplegia, which resembles closely the paraplegia of the disease, but the pain is located posteriorly and is acute; there is no reflex spasm. Muscular rigidity yields under firm pressure and the onset is unusually sudden.

*Hip Disease.*—This begins as does Pott's, which resembles hip joint affection when there is psoas abscess or inflammation. The lameness of Pott's is subject to remissions. There is limitation of motion of the limb in Pott's disease when the psoas is irritated, which limitation is confined especially to forced extension. There is no pain in the knee. The patient is able to stand on one foot as well as on the other. In hip-joint disease this is not the case, and you have no fixation of the spine.

In infantile paralysis the electric reaction is of service. There is usually severe pain and temperature for several days prior to the paralysis, no rigidity of the spine, and atrophy of the muscles of the leg with loss or diminished reflexes.

There is great danger in mistaking the tuberculous abscess for simple adenitis. Always remember, as a rule, these are superficial and acute, whereas psoas abscesses are chronic and deep-seated. Where they rupture into the vagina, the mistake in diagnosis may be made, diagnosing it a specific infection.

In closing, permit me to say, always look carefully for muscle spasm, deformity, increased reflexes, evening rise of temperature, paraplegia, and lastly, the abscess.

#### THE PRESENT STATUS OF BLOOD VESSEL SUTURING.

By Nathan Winslow, M.D.

Since the introduction of antiseptic and aseptic surgery, practically no structure or organ has been immune to surgical invasion, but only at a comparatively recent date, through the brilliant experimental researches and studies of Carrel, Murphy, Abbe, Githrie, Matas, Lund, Sherman and others, has serious attention been attracted to the possibilities of operation on the vascular system, though Hallowell, an English surgeon, demonstrated its practicability as early as 1759, when he repaired a small rent in the brachial artery by passing a pin through the edges of the wound and winding a thread round it. The studies of these investigators have shown conclusively that tears in blood vessels heal kindly after suturing, that it is possible to bridge a gap by implanting a segment of a vein, that after resection of an artery its vascular integrity may be restored by end-to-end anastomosis or lateral

anastomosis, and that the circulation through an artery can be entirely controlled by suturing its intima.

Phleborrhaphy is employed when complete ligation is undesirable, and when lateral ligation without obliteration of lumen is impossible. Its most common application is in longitudinal wounds, though its service may be invoked in tears of any direction. A vein completely divided across can be united by end-to-end suturing. The innominate, jugular and inferior vena cava, following operative trauma, have been sutured with gratifying results.

Arterial suture finds employment after resection of a vessel when incorporated in a malignant growth, after extirpation of aneurism, as a result of tear during operation.

Perhaps the reason for apathy in blood vessel surgery is to be found in the facility with which a collateral circulation ensues in most instances after ligation of a vessel, but why subject the patient to the hazard of gangrene when a reasonably safe and practical method of vessel suturing has been evolved. As a matter of fact, many wounds in large vessels are now sutured which, until very recently, would have been ligatured. The wonderful experiments of Carrel and the brilliant studies and operations of Murphy have been the chief agencies that have brought vascular surgery to its present development. Braun reports the excision of a segment of abdominal aorta torn half across while operating on a retroperitoneal growth with union of the cut ends with gratifying success. He first attempted suture of wound by single layer of suture, but leaking continued, and as a second row when placed so stenosed the vessel as to obliterate the pulse below the seat of injury, he was compelled to resort to end-to-end suturing with a happy result. Kuemmel, while removing a malignant growth of the groin, excised the femoral and successfully invaginated the central into the distal end. Amongst others, Stewart, Lund, Sherman, Murphy, Harrison, Depage, Pringle, Pasha, Torrance, Da Costa, Martin, Henderson, Halstead, Lexer, Manteuffel, Faykiss, Heidenhain, Payr, Orlow, Seggel, Krause and Lindner have succeeded in suturing wounded vessels.

The field of vascular surgery to date has merely been scratched, but much has already been learned. We know that a lateral wound or a transverse wound of less than half the circum-

ference of the vessel can be closed by suture, that end-to-end suturing can be performed, that a piece of resected vein can be inserted in an arterial gap to re-establish vascular continuity, and that after such an operation the sutured artery will carry blood for a time, but how long the flow will continue after the operation has as yet not been determined, some being of the opinion that the ultimate fate of the artery is gradual obliteration as a result of endothelial proliferation. Be this as it may, the end gained is sufficient to warrant the procedure, as the collaterals are dilating as the closure proceeds, and by the time one source of supply to the tissues is cut off, another has taken its place, thus preventing gangrene. Yet how are we to account for the re-establishment and maintenance of circulation in the case of the transplantation of a leg from one dog to another? In this instance certainly the restoration of the current has been permanent, and it now is coming to be accepted that the permanency of the current depends on the care and attention bestowed on the repair of the defect. There seems to be a certain amount of danger of the development of aneurysm at the seat of suturing, but this is more theoretical than real.

To assure a successful issue the following technique is requisite:

Perfect asepsis.

A clean-cut wound of vessel.

Absence of tension on sutures.

No rough handling of vessel.

An efficient and non-injurious method of obtaining temporary hemostasis.

Proper suture material.

Absolute asepsis is a prerequisite to success. Infection spells failure. Another essential to a favorable outcome is a clean-cut wound of the vessel. Tags floating in the blood current causes coagulation of the blood, with a consequent obliteration of the vessel. Any undue tension of sutures is followed by their cutting out with disastrous results. Very fine silk threaded on intestinal needles is the best suture material, but catgut may be employed if preferred. The latter material swells and thus fills the needle puncture, acting thereby to some extent as a hemostatic to these holes. Carrel finds it most important to impregnate the suture thoroughly with sterile vaseline so as to prevent the deposit of clot on the thread. Probably in this simple procedure lies the reason for the latest successes in arterial sur-

gery. Several agents are employed to control the blood circulation previous to suture, but whatever form of hemostasis is used, it must be used most gently, only pressure barely sufficient to stop the circulation being exerted. Occasionally the elastic constrictor is used, in other instances the fingers of an assistant, but some form of mechanical device gives the best service. Fine linen tape thrown around the vessel and fastened by forceps answers the purpose admirably. But clamps, the blades of which are covered with rubber tubing, are the most serviceable.

A longitudinal wound or a transverse wound of not more than one-half the circumference of the vessel, after its temporary occlusion, may be closed by continuous or interrupted suture, passing the thread either through all the coats, in which event they should be impregnated with vaseline, or only through the two outer coats and bringing the edges of the wound together without inversion. Suturing through the two outer coats without inclusion of the intima is applicable only to the largest vessels, and further labors under the disadvantages of the possibility of fringes of the intima projecting into the blood stream, and thus favoring coagulation, and again of blood passing through the inner lining, causing aneurysm.

If the edges are lacerated or contused, they should be pared. All clot should be turned out, the lumen washed with hot normal salt solution, then greased with vaseline. Remove any of the outer coat which is projecting between the edges of the wounded vessel, for if any of these fibres come into contact with the blood, thrombosis occurs. Then, according to the operators preference, pass a sufficient number of interrupted sutures of the finest silk, threaded on an intestinal needle as directed above, and close the aperture without inversion or undue tension on the sutures.

Circular arteriorhaphy is of value when a vessel of size has been completely divided or a portion of it has been excised. The same general rules laid down for arterial suture apply to end-to-end anastomosis. Completely remove all fibrous tissue about ends of vessel. During operation keep the vessel from drying either by moistening with salt solution or by applying sterile vaseline. When union has been effected there is rarely any oozing, and such as there is can easily be controlled by pressure. Of the many operations for the restoration of the continuity of a vessel, Murphy's

method may be taken as an example. A fine cambric needle threaded with fine silk is passed through all the coats of the distal segment about one-third inch from the wounded edge. Bring the needle out through the open end of the vessel; with the needle pick up a portion of the two outer coats of the proximal segment of the vessel at about one-third inch from the cut surface. Introduce the same needle through the open end of the lumen of the peripheral segment and make it penetrate from within outward the whole thickness of the vessel. Insert two or three more such sutures. Pull on sutures and so invaginate the proximal into the distal segment of vessel. Tie the sutures. Before invaginating it may be necessary to make a slight longitudinal slit in the distal segment. With fine sutures unite the edges of the distal to the side of the proximal segment at the line where the former overlaps the latter. If a longitudinal slit has been made, close it with a stitch. Carefully suture any available tissue near the vessel in such a fashion as to give maximum support to it. The overlying tissues are united with exception of a small opening leading to site of suture through which a rubber drain is inserted. Dress as any other operative wound and immobilize part if possible. The drain is removed in twenty-four hours. The stitches are taken out on the tenth day. Immobilization should be maintained for at least three weeks, with patient during this time confined to bed.

It is too early as yet to accurately determine the place this procedure is to occupy in modern surgery, but enough work has been reported to guarantee its feasibility, and we are of the firm opinion that in the future it is to be widely employed, where in the past ligaturing was the accepted principle.

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The editors of the BULLETIN are in receipt of the following letter from Dr. Francis E. Jamison, class of 1907, of Newport, Md.: "Kindly accept check for subscription to HOSPITAL BULLETIN. It is a valuable little pamphlet, and I enjoy its contents immensely. It keeps me in thorough touch with the greater number of my colleagues and classmates, and furthermore enlightens me in medical literature that I could not get elsewhere. I am enjoying a lucrative practice, and am health officer of my native county—Charles. Wishing the HOSPITAL BULLETIN continued success, I am, very truly, Francis E. Jamison."

# THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, Md., SEPTEMBER 15, 1910.

## THE NEW OBSTETRIC WARDS AT THE UNIVERSITY HOSPITAL.

The Maternity Hospital of the University of Maryland, formerly located at 622 West Lombard street, was established by the Faculty about 1887 at the instigation of Prof. George W. Miltenberger. During the time of its existence a great work has been done in its wards, and in the outside obstetric clinic, as is evidenced by the report of the department for the year ending May 1, 1910. The number of confinements in the hospital during this period were 201. The number of confinements in the outdoor department were 865, making the enormous total of 1066, or an average of 30 cases for each student in the graduating class. Notwithstanding these figures, the building was not well adapted to the purpose for which it was used, and from an administrative, as well as from a humanitarian and scientific, standpoint it became necessary to make other arrangements. The Legislature of 1908 appropriated \$50,000 for the purpose of extending the University Hospital, but the Governor, in the exercise of his wisdom, cut off \$25,000 from the appropriation, and thereby prevented the contemplated addition to the hospital. His Excellency also notified the Legislature of 1910 that any appropriations for buildings would be vetoed; hence they were not made. It was in contemplation to extend the University Hospital ninety feet to the west, and equip the new building as a maternity hospital; unfortunately this could not be done. The problem was solved by converting the old nurses' dormitory into wards and private rooms, with all necessary modern accommoda-

tions for the treatment of both pay and indigent patients. We are, therefore, better equipped for the care of lying-in cases, and for the teaching of obstetrics, than ever before in the history of the institution.

## NEEDS AND REMEDIES.

The cost of medical education is continually increasing. The demands of the times require an extensive equipment in the way of laboratories, apparatus, books and teachers. The Council of the American Medical Association, the Carnegie Foundation, and various other organized bodies are clamoring for at least five fully equipped laboratories with full time teachers who shall devote their time to teaching and research exclusively. This may or may not be desirable, but the handwriting is upon the wall, and willy nilly the edict will have to be complied with within a comparatively short time. It is useless to close our eyes to patent facts. It is estimated that each laboratory should have an endowment of at least \$100,000; certainly \$5000 a year would not be a large amount to devote to each laboratory. Some laboratories would require a greater expenditure than others.

The Faculty of Physic of the University of Maryland is absolutely honest. It does not profess to do those things that it cannot do. At present there are but two professors who are not practitioners, and they are both in the chemical department. The chairs of anatomy and physiology are filled by able and accomplished teachers who devote a large portion of their time to teaching, but not all of it. The chair of pathology is also occupied by an able and conscientious teacher, with a corps of assistants, who cannot devote their entire time to pedagogical duties. Probably the most urgent need of the school at this time is an endowed department of pathology. As we have said, it is certain that five full time teachers will have to be supplied in the near future. How shall this be accomplished? The tuition fees of students are about as high as can be expected, and are not adequate for this purpose. There are but two ways in which it can be accomplished. First, by endowment; and second, by consolidation in part or in whole with one or more existing schools. In either case the first essential is money. For ten years we have endeavored to secure an endowment fund, and the result of the

effort amounts to about \$28,000. We are thankful for this sum, but it is merely a nucleus and must be considered as such. At present only the three scholarships are available for immediate use. Certain other sums have been devised to us, but they may not be available for some time. An increased effort is to be made to secure more means, but it will certainly not eventuate sufficiently to relieve our necessities in the near future. Whilst we raise the Macedonian cry, "Come over and help us," we must also take such measures as we can to meet the demands of the times. Now for the second alternative. Two or three of the existing medical schools ought to be merged together and form one strong school. As the three larger schools draw students from very different localities, their consolidation would result in a large school with pupils coming from very varied directions. We think this arrangement very desirable. If this cannot be effected, then the first two years of the course might be held in common, whilst the clinical years could be distinct. In this manner the laboratory branches could be taught by full time teachers, whose whole time could be devoted to teaching, whilst their salaries would be paid jointly by the three schools.

## EXTRACTS

### BUSINESS METHODS OF PRACTICE.\*

By ARTHUR E. EWENS, M.D.,  
(Class of 1904, University of Maryland.)  
Atlantic City, N. J.

There is abundant reason for assuming that very few men enter the medical profession solely in quest of worldly gain, because statistics relating to the income of the average physician, and more particularly to his financial standing at the close of his professional career, certainly would not encourage anyone with strong mercenary tendencies to choose this field for his life-work. On the other hand, I do not believe that there is a very large percentage of practicing physicians who, when they resolved to undertake the study of medicine, were actuated merely by a charitable impulse and with the single purpose of assisting in the relief of human suffering, though this desire should, and naturally does, occupy a prominent place in the

aims and ambitions of every conscientious doctor. We would perhaps arrive more nearly at the truth of the matter were we to assume that the average young man who contemplates preparing himself for the practice of medicine does so, first of all, because of natural bent, or perhaps because he aspires to a profession and believes that his college training, and probably his environment, has best fitted him for the pursuit of medical study. Having assured himself that he possesses, at least to some degree, the proper temperament and taste for the work he has in view, the next question that naturally arises is whether the practice of medicine will be sufficiently remunerative to afford ample means of support for himself and his family. Since most of us must have had this thought in mind when we entered upon our course in medicine, the fact that we proceeded with our studies and adopted the calling goes to show that we did expect it to yield us at least a comfortable living. Had our conclusions been to the contrary, I am quite sure that the majority of us would have turned our attention to some other pursuit in which the outlook seemed more promising. In making this statement it is not my desire to give any undue prominence to the financial considerations that enter into the practice of our profession, for no physician is worthy of his calling if he permits his work to be dominated by purely selfish motives. I merely wish to call attention to the fact that money matters do demand a reasonable share of attention, inasmuch as our practice is, with the vast majority of us, our sole means of earning a livelihood.

As to what constitutes good business methods, each man must, of course, decide for himself, and there is necessarily a great diversity of opinion upon this subject. Every physician should, however, give this matter thoughtful consideration in order to establish in his own mind a definite idea of what he really would consider good business principles, and then diligently apply these principles to his every-day work. It is of the utmost importance to begin right, for when once we have become accustomed to certain methods, whether they be good, bad or indifferent, it is usually found to be a pretty hard matter to change our original plan of procedure.

One of the first essentials is a proper understanding of bookkeeping. Without an adequate knowledge of this simple process no physician can keep a systematic and reliable record of his work.

\*Read before the Atlantic County Medical Society, Atlantic City, March 11, 1910.

A charge should be entered for every service rendered, and credit given for every dollar collected. Not a single item ought to be entrusted to the memory, nor should a day close without every charge and every credit having been carefully transferred from the day book to the ledger. If this latter procedure is made a matter of daily routine, it is always practicable to turn to our ledger and ascertain at a glance the exact amount that is due on every patient's account. Many a physician who is lax in his bookkeeping is occasionally made to realize the significance of this apparently minor consideration when a patient, desirous of settling an account, walks into his office at a busy hour and he finds himself unable to make out a bill without the tedious operation of going all through his day book or day cards in order to ascertain the number of visits he has made. In many instances he cannot spare the time necessary for this sort of thing, and is compelled to make some apology to the patient, assuring him, perhaps, that a bill will be forwarded in due course, or something to that effect. This attitude on the part of the physician certainly does not reflect any credit upon either himself or his profession from a business point of view, and is apt to be construed by some people to indicate an utter indifference to financial matters. Should we be surprised, therefore, that certain patients, who are well able to pay for medical service, show a corresponding degree of indifference when we remind them of their indebtedness?

Before leaving this subject of bookkeeping it might be well to call attention to the reasons that physicians usually give for their lack of systematic attention to this very essential duty. The principal excuse is that they haven't time. It has always been difficult for me to reconcile such a statement as this with the fact that a matter so simple as the bookkeeping of the average physician requires but a very few minutes each day. Other doctors will tell you that they do not succeed in keeping a set of books satisfactorily because they despise bookkeeping or because they have never taken occasion to familiarize themselves with the principles involved. These men would certainly find themselves in a most embarrassing predicament should any legal proceedings arise that would require them to produce their books as evidence. Whenever a physician, for any reason, finds it impracticable to attend personally to this department of his work he will be sure to profit by the employ-

ment of a competent person to look after it for him.

The question of medical fees is rapidly becoming one of vital importance to the profession. Of course, a physician with an established reputation experiences little or no difficulty in maintaining fees that are fully commensurate with the value of his services but there appears to be a tendency on the part of some members of the profession to undercharge their competitors in order to advance the number of their patients. Unfortunately it is not only some of the younger members who display this tendency, but we occasionally discover facts that convince us that even physicians who have attained a fairly prominent position are not upholding adequate fees—though we may do the latter class an injustice if we attribute this in every instance to a mean motive. When a physician uses his brother practitioner's scale of fees to enhance himself by "cutting under," he descends to a very low level, indeed, and it is questionable whether such a deplorable method will enable him to prosper in the long run. But, whether men of this character prosper or not, their actions certainly do the profession a great injustice by tending to create in the minds of some people a false impression as to what a just charge for professional services should be.

Another very prevalent evil is the willingness of some physicians to permit their patients to dictate terms to them, or to make reductions to suit and please their patients. This is undignified and brings the profession into disrepute, besides being unjust. If your services are not worth what you have charged for them, say so and take less, but do not underrate these services by reductions that are ridiculous from a business standpoint. In making out a bill, especially if it be for services rendered during a long illness, we should always have due regard for the patient's means, and make our fees, as nearly as possible, correspond with the person's ability to pay. Having done this, we should never under any circumstances receipt a bill in full upon the payment of only two-thirds or three-fourths of the entire amount. Whenever this is done the natural presumption must be that we acknowledge an overcharge and do not, therefore, consider our services worth what was originally asked.

Not only should we thwart the numerous attempts of patients to secure a reduction of our fees, but we should also put a stop to the schemes of designing people who frequently succeed in

obtaining advice in such a manner as to escape any charge at all. I have reference, particularly, to the use of the telephone. Whenever anyone chooses this means of consulting us there is no just reason why a fee should not be charged, and for advice obtained in this way I should think it would be altogether proper to make the same charge as for an office consultation.

Without going further into the question of fees, though it is one about which a great deal more might be said, let us direct our attention for a few moments to the subject of collections. As previously stated, many doctors frankly admit that they are "poor collectors," and we frequently hear of a physician who, at his death, was found to have had on his ledger unpaid accounts aggregating many thousands of dollars, which were not worth the paper on which they were written. The average physician's ledger would not contain so many uncollectible accounts if he would take the pains to inquire of every new patient who his former physician was, and then ascertain from that physician the patient's reputation for paying his bills. If this practice were universally adopted it would not be such an easy matter for dishonest people to impose upon doctor after doctor as so many of them do. Such people find the young physician an especially easy victim because of his eagerness to acquire a practice. Probably the most effective means of preventing this wholesale imposition would be for all the physicians in a town to contribute yearly to the maintenance of a "black-list."

The physician himself is many times to blame for his failure to collect outstanding accounts, and the majority of these accounts would not attain any great size if he would adopt the plan of sending out bills at frequent intervals. There is no one thing that occasions so great financial loss to a physician as procrastination in the matter of sending out bills. To mail a statement of the balance due on *every* account the first of each month entails considerable work, it is true, but this practice is productive of such a decided increase in the percentage of collections that its importance cannot, in my judgment, be overestimated. Many physicians, I know, have the erroneous idea that monthly bills are apt to offend their patients. There is no real foundation for any such notion. Have printed on your billheads—"Bills rendered monthly"—and if you carry out this rule to the letter I am sure that your collections will show an increase of more than 15 per cent. Furthermore,

I would be willing to wager that whenever you lose a patient because he takes offense at your methods a careful investigation into his reputation for meeting his obligations will convince you that he is "N. G."—*Journal of the Medical Society of New Jersey, June, 1910.*

Dr. Ewens' article evoked the following editorial in the same issue:

#### BUSINESS METHODS OF PRACTICE.

Among the original papers in this issue of the Journal is one by Dr. A. E. Ewens of Atlantic City, on the above subject, which is timely. It is true that the medical profession is one of the most altruistic of all bodies or classes of men, and is most free from the spirit of commercialism. It is equally true that for the exhibition of true charity that is purely voluntary and for free service that is forced upon the profession that is very often downright imposition because the recipients are not proper objects of charity, our profession certainly exceeds all others. Then if we add to all this what hardly comes under the head of charity, but rather patriotism and love for humanity, which is the greatest work and glory of our profession—its persistent and self-denying efforts in developing, establishing and advancing preventive medicine, which means hundreds of thousands of dollars out of the pockets of medical men of New Jersey annually, surely it needs no argument when we affirm that there is ground for the question often asked, if the profession is not impoverishing itself, and there is need of just such thought as Dr. Ewens' paper presents for our consideration.

It is not our purpose at this time to discuss this paper, but simply to call attention to it, that it may receive the consideration it deserves.

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#### THE PRESENT STATUS OF THYROID SURGERY.

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There have been more operations performed on the thyroid gland in the past ten years than in the entire 1899 years preceding. (H. D. Purdum, M.D., class of 1902, formerly assistant physician Northern Michigan Asylum, Traverse City, Mich.; superintendent of the Insane Department, Bay View Hospital, Baltimore, Maryland.—The *Journal of the Michigan State Medical Society, August, 1910*). Years ago the mortality following thyroid operations was on an average of from 25 to 45 per cent.; now in the experienced hand

it ranges from four-tenths of 1 per cent. to 4 per cent. The Kochers of Europe and the Mayos of the United States have been the leaders in this hitherto unexplored department of surgery, and it is to these great surgeons that we owe our present knowledge of the subject. The surgeons of the past shunned operations about the neck, and most of those of the present day do not enjoy goitre operations. For the above reasons diseased thyroid glands were allowed to wreck the general health of patients to that extent where operations, if performed, were of no benefit and most frequently fatal. The day for treating thyroid glands with semi-surgical, medical, mechanical and electrical means is past. The operative treatment is most satisfactory, giving immediate relief in the majority of cases with but a brief period of disability.

The general technique of this operation is the same in all cases where the gland is of considerable size and may be outlined as follows: The patient and field of operation are prepared as for any major operation. The kind of anesthetic used is selected to suit the individual case; but ether is most frequently employed, preceded by a hypodermic injection of morphine, 1-6, and atropin, 1-150. In some cases it is advisable to use some local anesthetic, and in others chloroform is preferable. After the patient is placed upon the table it is advantageous to place beneath the back of the neck a firm pad or sandbag to make the gland more prominent and to give the operator more freedom. From now on the technique is that used by Kocher and is known as "Kocher method." This method is employed by most operators with few modifications. First a transverse curved incision is made over the most prominent portion of the gland with the convexity of the curve towards the sternum. The anterior jugular veins are exposed and tied above and below; the incision being made between the ligatures. The upper portion of the jugular veins are then elevated with the flap, including the skin, superficial fascia and platysma myoides muscle. Now the sternohyoid, sternothyroid and omohyoid muscles are cut across at a higher level than the skin incision to prevent sinking in of the neck from scar tissue contraction, and also to preserve the nerve supply to these muscles. The capsule of the gland is easily reached from this point by blunt dissection. The capsule has the appearance somewhat of the peritoneum, being

silvery and glistening. The capsule is now opened and the finger passed between it and the gland from which it is easily separated. When the superior and inferior thyroid arteries and veins are found by the sense of touch they are tied off.

It is a good practice to include a small portion of the glandular tissue within the ligature to prevent slipping, and also to keep from injuring the parathyroid bodies that lay within the immediate neighborhood. The lobe is then freed and the isthmus tied and cut. Kocher advises tying the isthmus (*en masse*) and applying to its cut surface pure carbolic acid, followed by alcohol. Dr. Purdum has found in his personal experience that mattress sutures of catgut are more capable of stopping the post-operative oozing of blood and thyroid secretion from the isthmus than is the simple ligature. However, in any method used, it is proper to apply carbolic acid to the cut surface of the gland to close up the spaces as well as the minute capillaries. If this searing method is not employed a considerable quantity of thyroid secretion escapes into the surrounding tissues and is reabsorbed, presenting a train of symptoms not unlike acute thyroid intoxication.

Before suturing a wick of gauze is placed in the most dependent portion of the wound and the muscles as well as the skin united around it. Following the majority of operations on the thyroid gland the patients are shocked, and to combat this shock normal salt solution, subcutaneously administered, has proven of great benefit.

The drain should be left in the wound from two to four days, after which it is removed and the canal irrigated with some mild cleansing and stimulating solution. The above outlined method, with few variations to suit the individual cases, may be used in any operation on the diseased thyroid. When the gland is very small it is often not necessary to make the transverse incision, but to use instead a vertical incision between the anterior jugular vein and the sternocleidomastoid muscle. After this incision is made one can separate the underlying muscles and reach the lobe of the gland without cutting them across. The scar following such an incision is almost invisible and the tissues of the neck show no shrinking or falling in.

Operations upon colloid, simple or diffuse adenomata and upon encapsulated adenomata, as a rule, involve but slight risk to life of the indi-

vidual. For the above reason many patients who are so afflicted wish to be relieved of the deformity, tracheal pressure, cough or hoarseness, or possibly a severe neuralgia. We must admit that aside from the discomforts mentioned above, the death rates from these forms are very low, and only then from the intrathoracic type or from malignant or degenerative changes in the gland. There are a number of cases in the Northern Michigan Asylum in which the measurement exceeds 20 inches, and in one particular case the neck was 28 inches without any severe symptoms being manifest.

In the other great class of cases commonly known as exophthalmic goitre the prognosis is not quite so good. Mayo prefers to use the term hyperthyroidism instead of exophthalmic goitre, because he believes it will come into general use in describing a condition which manifests such varied symptoms. By using this term it is possible that an early diagnosis will be made and surgical relief given to those who are now treated for heart disease, nervous prostration, gastric crisis and intestinal toxemia until a projecting eyeball or goitre becomes sufficiently prominent to attach the label of Parry's disease, Graves' disease, Basedow's disease or exophthalmic goitre to the unfortunate individual who must run the gauntlet of the enormous variety of therapeutic agents which are supposed to be good for the disease when properly christened. It is quite probable that many cases of hyperthyroidism never progress beyond the early stages and are not diagnosed as such. It is also probable that many cases in the advanced stages of the disease get well without or in spite of medical treatment. Mayo claims that one-quarter of the number do so. In examining the gland in 294 cases of hyperthyroidism, Ewing, McCallum and Wilson were able to show a definite change in the parenchyma of the gland in this type of disease. The results from the reduction of secretion by surgical methods are certainly almost marvelous. Before the last decade the mortality following operations for hyperthyroidism was some 45 per cent. Patients frequently died upon the table on account of their poor physical health at the time of the operation. A great many suffered from fatty myocarditis, some from parenchymatous nephritis and others showed arterial degeneration

with fatty changes in the parathyroid glands. Today these cases are recognized earlier and operative treatment given without such fatal results. Mayo has adopted a method of treatment that seems to me to be very appropriate in neglected cases with poor physical health. His method is to first under a local anesthetic tie off the superior thyroid arteries and veins on each side as a preliminary procedure. By doing so the gland is relieved of its enormous blood supply and its functioning power obtained, whereby the patient is permitted to gain enough strength to stand the radical operation later. Occasionally this preliminary treatment is all that is necessary to balance the metabolism of the patient, but if not sufficient a second operation is performed and one lobe of the gland removed. The dangers encountered in these cases are shock, hemorrhage, auto-intoxication, infection and pneumonia. Collapse of the trachea is also mentioned by Mayo among the causes of death. You all, no doubt, are fully aware that the pressure produced by the lobes upon the trachea causes a softening of the cartilaginous rings, and when the gland is removed the trachea collapses. One other precaution that is necessary in this operation is to be careful not to wound or cut the recurrent laryngeal nerve, which, if destroyed, produces paralysis of the vocal chord on the affected side. The parathyroids also must be spared, because if injured or removed tetany is liable to follow. One case at the Northern Michigan Asylum showed tetany on the fifth day following the operation and lasted for two days. The symptoms were not severe and were promptly relieved by the administration of thyroid extract, which contains also extract of the parathyroids. Mayo advises in operating for hyperthyroidism when the auto-intoxication is profound, to remove one lobe with the isthmus and tie the superior thyroid artery on the opposite side.

The prognosis following operations for hyperthyroidism is good. Sixty-five per cent. recover completely. Thirty per cent. are markedly improved and five per cent. are unimproved.

In operating upon the thyroid gland, always leave the posterior portion of the capsule. If this precaution is taken, injury to the parathyroids and the recurrent laryngeal nerve is seldom encountered.

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Prof. R. Winslow, M. D., Prof. T. A. Ashby, M. D., Prof. J. Holmes Smith, M. D., Prof. J. M. Hundley, M. D., Prof. Hiram Woods, M. D., Prof. Frank Martin, M. D., Prof. St. Clair Spruill, M. D., Prof. John R. Winslow, M. D.

CLINICAL ASSISTANTS FOR 1910-1911.

B. J. Asper, Pennsylvania; W. C. Bacon, Maryland; B. S. Boyer, Maryland; A. E. Brown, North Carolina; E. S. Bullock, North Carolina; W. L. Byerly, Maryland; H. D. Causey, Delaware; H. A. Codington, Georgia; R. C. Dodson, Maryland; J. J. Edelen, Maryland; R. G. Hussey, North Carolina; C. L. Joslin, Maryland; M. R. Kahn, Maryland; W. Linn, New York; P. P. McCain, South Carolina; M. E. Mallen, Porto Rico; W. C. Maret, South Carolina; G. Y. Massenburg, Maryland; W. S. Niblett, Delaware; E. E. Nichols, Delaware; V. L. Oler, Maryland; T. Ramirez, Porto Rico; C. L. Schmidt, Maryland; R. L. Taylor, Georgia; J. E. Thomas, South Carolina; G. D. Townshend, Maryland; C. A. Waters, Maryland; E. C. West, Delaware; J. C. Wilkins, North Carolina.

The total number of patients treated in the Hospital during the year 1909-1910 was 4948.

THE UNIVERSITY TRAINING SCHOOL  
FOR NURSES.

Under the guidance of the Superintendent, the pupils of this School are instructed in all that pertains to Scientific Nursing. Lectures are also delivered to them by the members of the Faculty of Physic, on Elementary Anatomy, Physiology, Materia Medica, Chemistry, Antiseptics and Hygiene, as well as upon Nursing in special practice. The Nursing in the Hospital is thus conducted on the most approved plan, and its large material is invaluable to the pupils of the School.

For circulars and information about the Training School, address

MISS ALICE F. BELL,  
Superintendent of Nurses,

Hospital of the University of Maryland,  
Baltimore, Md.

MATERNITY HOSPITAL OF THE UNI-  
VERSITY OF MARYLAND.

Prof. L. E. Neale, M. D., Director.  
E. H. Kloman, M. D., J. B. Nicholls, M. D., R. D. McMillan, M. D., Resident Physicians.

SYNOPSIS OF THE REPORT OF THE RESIDENT PHYSI-  
CIALS FOR THE YEAR ENDING MAY 1, 1910.

Number of Confinements in Hospital.....	201
Number of Confinements in Out-door De- partment .....	865

Total ..... 1066

Average number of cases seen by each student of  
the graduating class, 30.

ITEMS

Miss Annie E. King, class of 1903, Training School for Nurses, is in charge of the Baltimore Eye, Ear, Throat and Nose Hospital, and Misses Florence E. King and Margaret Taylor, both of the class of 1910, have accepted positions as head nurses in the same institution.

Dr. Harry Downman McCarty, class of 1905, of 613 Park avenue, Baltimore, has been canoeing on the Shenandoah River.

Dr. Nathan Winslow, class of 1901, has removed from 3112 West North avenue to 3304 Walbrook avenue.

Dr. Michael J. McDermott, class of 1910, is

located at Columbus Hospital, 226 East 20th street, New York city.

Dr. John Edgar Rooks, class of 1905, of Doyline, La., is the president of the Webster Parish Medical Society. Last year Dr. Rooks filled the office of secretary to this society.

Dr. Louis McLane Tiffany, class of 1868, of Baltimore, has returned from Magnolia, Mass., and is spending some weeks at Mt. Custis, his country place at Accomac, Va.

Dr. John R. Winslow, class of 1888, who, with Mrs. Winslow, has been visiting abroad, writes from Berlin as follows:

"On the trip over the water was mostly smooth, and neither of us was seasick, but the weather was very variable and at times so cool as to be unpleasant. On our arrival here we went first to the Bristol Hotel, but later came here to the Pension Hoeven, which is directly opposite the Charité Hospital. I have been very busy ever since arranging for instructions and visiting various clinics. I have been very fortunate in obtaining the personal instruction of Herr Wolff, one of the assistants of Professor Brühl, and am taking a course in advanced mastoid work on the cadaver and on the living. I have also the run of Professor Brühl's clinic, and assisted him at a radical mastoid operation by invitation. Also visited him at home to see his wonderful collection of specimens. I have also visited Herr Jansen's clinic, and learned more in two hours than ever before in my life in a similar time. Friday I visited Haller's clinic, another celebrated otolaryngologist. On the whole, I am delighted with what I can get here. In some respects they are far and away ahead of us, while in others, such as tonsil work, they are way behind. I consider that I am well repaid for my trip by what I have already learned, but expect to get more. My German is returning to me, and I take my instruction in German and converse almost entirely in that language. Two young Baltimore doctors, Clapp and Knower, are staying here at the Pension. Dr. Thomas R. Brown of Baltimore occupied our rooms just before our arrival, but we did not meet him. We leave here in about 10 days for Holland, and sail for home on the Noordam-Holland-America Line August 20, arriving in New York August 30 or 31."

Dr. Andrew E. Bell, class of 1897, is located in Mooresville, N. C.

Dr. Harry Young Righton, class of 1907, is located in Savannah, Ga.

Dr. J. E. Langley, class of 1910, is located at 1129 Baldwin street, Williamsport, Pa.

As far as can be ascertained, members of the class of 1901 are located as follows:

Carl Richard Ahroon, Baltimore.

Harry Ainsworth, Thomasville, Ga.

Edgar G. Ballinger, Atlanta, Ga.

John I. Barron, Yorkville, S. C.

Francis Carey Bayne, Roland Park, Md.

James A. Bond, Baltimore.

Paul Richard Brown, Jr., Guthrie, Okla.

Ashby Clifford Byers, Lacey Springs, Va.

Thomas Harris Cannon, Baltimore.

Richard Perry Carman, Baltimore.

Edward de Viel Castel, Mexico.

Homer E. Clarke, Oak Grove Sanitarium, Flint, Mich.

Charles C. Cook, Washington, D. C.

George H. Costner, Lincolnton, N. C.

William Henry Coulbourn, Crisfield, Md.

Benjamin H. Dorsey, U. S. N.

Norman Spear Dudley, Church Hill, Md.

Charles W. Famous, Street, Md.

Frank Cline Ferguson, Baltimore.

Charles Thompson Fisher, Jr., Princess Anne, Md.

John Edward Foscue, Jamestown, N. C.

R. Claude Font, Kempton, Md.

Charles Wesley Gardner, Pittsfield, Mass.

John Aldridge Gibson, Leesburg, Va.

Albert Henry Gieschen, 1103 E. 156th street, New York.

Robert McCheyne Glass, Winchester, Va.

W. W. Goldsborough, Greensboro, Md.

Abraham Grunberg, Roumania.

Robert Lee Hall, Pocomoke, Md.

Jurgi Simai Hanna, Tanta, Egypt.

Albert Scott Harden, Newark, N. J.

William Franklin Hargrove, Kinston, N. C.

E. Roland Hart, Suffolk, Va.

Musa Yuhanna Hassun, Damascus, Syria.

John Mortimer Hayes, Baltimore.

John Wise Hebb, Jr., West Friendship, Md.

George W. Hemmeter, Baltimore.

J. Horace Jenkins, Elkton, Md.

Edward Lake Jones, East Newmarket, Md.  
 John Pollard LaBarre, Waltersburg, Pa.  
 Guy Walter Latimer, Hyattsville, Md.  
 Percy E. Lilly, Baltimore.  
 William L. Mauldin, Jr., Greenville, N. C.  
 Walter Humphrey Mayhew, Sabillasville, Md.  
 Walter Teed Messmore, Smithfield, Pa.  
 J. V. Milton, Hamilton, Va.  
 Evans M. Myers, Bennett, Neb.  
 Edward C. McEachern, Rockingham, N. C.  
 Watson Smith Rankin, Raleigh, N. C.  
 James Dawson Reeder, Baltimore.  
 Thomas Eben Reeks, New Britain, Conn.  
 Francis O. Rogers, Concord, N. C.  
 William Russell Rogers, Bristol, Tenn.  
 William Fulford Sappington, Webster Mills, Pa.  
 Louis Cotton Skinner, Greenville, N. C.  
 Richard H. Speight, Jr., Morgantown, N. C.  
 John Henry Stemple, Jr., Conshohocken, Pa.  
 Dunlop Thompson, Marion, N. C.  
 Thomas Swann Tompkins, Chilton, W. Va.  
 S. Parks Watson, Little River, S. C.  
 Edward Dawson Weems, Solomon's Island, Md.  
 J. Marshall B. West, Catonsville, Md.  
 Albert F. Williams, Jr., Kenansville, N. C.  
 Nathan Winslow, Baltimore.

The following could not be located: Frank C. Heath, Richard Mobley Little, Ross Halford Miner, William Madison Riley.

The following are dead: William Emmet Kornegay, Frederick E. Medina and Harry Blackburn Smith.

In this class of 71 members all but four members, or 59-20 per cent., can be accounted for.

Dr. William Royal Stokes, class of 1891, spent August at the Burg Ainwick, Ellicott City, Md.

Plans have been completed for the new home of Prof. John C. Hemmeter, class of 1884, to be located on University Parkway, Roland Park. The house is to be built along colonial lines, and will cost \$35,000.

Dr. J. William Funck, class of 1888, has returned to the city, after spending the summer in Ocean City, Md.

Dr. Charles W. Larned, class of 1893, has been camping in Maine.

Dr. Henry Otfrage Reik, class of 1891, has been spending several weeks in Canada.

The committee on endowment of the University of Maryland has planned a campaign this fall to raise a large fund. While the official announcement has not as yet been made by the committee in charge, plans have been formulated by them for the raising of a sum of money which will place the University upon a better basis.

Many of the alumni are not satisfied with the standing of the school in the field of education. While some of the greatest physicians, surgeons and lawyers in the country, men who have established national reputations in their individual fields, have passed through its doors, the University, according to the alumni, is not enjoying the prestige which it rightfully deserves.

They do not blame this upon the teachers, methods of study or any other features of the curriculum, but solely to a lack of funds. Owing to the advance in knowledge and requirements and the great expense thus imposed, the University finds itself under an ever-increasing strain.

"It is a shame and disgrace," said an alumnus of the University recently, "that an institution of such rank, that has passed its century mark, should be in need of funds. This is, indeed, regrettable, but it is nevertheless true. Thousands of professional men scattered all over the globe should pay tribute to their alma mater. I am confident that if the committee on endowment spreads the fact that the school needs funds there will be no difficulty in raising the necessary money."

The University of Maryland has not shared in the benefactions of this community as it should, and an urgent appeal for financial aid should meet with a ready response from our public-spirited citizens. Large amounts of money have been given to other institutions, both here and elsewhere, and it seems to me that a university of the age, standing and services of the Maryland University should receive a liberal portion of such gifts."

A considerable fund has already been quietly raised and is steadily growing. This fund is held by a board of trustees under a special charter of the Legislature, which secured for it absolute and perpetual inviolability. The interest on this can alone be used for the maintenance of the institution. Dr. Eugene F. Cordell, 257 West Hoffman street, is chairman of the committee on endowment.

Dr. Earle Holt Brannon, class of 1906, has returned to Baltimore, after two and a half years

spent in the wilds of Brazil, where he was in charge of the field hospital in connection with the building of the Mediera Mamore Railroad, which is to connect with the navigable portions of the Amazon River. This road is so difficult of construction that three years of work have only served to build 45 miles of railroad, and that at a cost of over \$3,000,000. Only the vast commercial possibilities of the Amazon have led the Brazilian Government to put so much capital into the enterprise. Dr. Brannon gives the following description of some of the difficulties encountered:

"The railroad begins 800 miles from the nearest settlement of any kind, and ends 150 miles farther away, and in that distance every known danger to man is encountered. It is one of the most unhealthy places in the world, and no man can live in this wilderness more than six months without being stricken either by malaria, yellow, typhoid, black water fevers, smallpox or beri-beri. The average man is stricken within three months, and no man can live there more than six months without being stricken. The death rate ranges in the neighborhood of 40 a month per 1000, and in each one of our camps a space is reserved as a graveyard, and in this the dead are buried without any ceremony.

"The Indian tribes inhabiting these sections are mostly nomadic and absolutely primitive. They never saw a white man until we entered their forest, and they wear absolutely no clothes, neither men nor women. Their idea of decorations is to have a stick run through the nose and shells in the ears. So evil are the health conditions of these people that they die off rapidly when they enter the territory where we were working. Just to the north and south of us were tribes noted for their ferocity; they are not only head hunters, but cannibals as well. They use poisoned darts, which they blow through a hollow tube, or reed, and once a person is struck by one of these darts it has the peculiar effect of paralyzing a person without deadening consciousness or sense of feeling. The Indians use human skulls for drinking cups, and make musical instruments out of shin bones.

"During the two years I was in this camp I never saw any fresh vegetables, with the exception of a potato, and consequently had to resort to canned goods. We encountered all kinds of wild animals and poisonous snakes, and were compelled to be on our guard all the time to prevent being

attacked both day and night. We encountered all classes of lawbreakers and criminals, who seek those parts to be free from prosecution."

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Dr. Perry L. Boyer, U. S. A., class of 1899, has been relieved from temporary duty at Fort Mason, Cal., and as attending surgeon, San Francisco, and on expiration of present sick leave of absence will proceed to Fort Clark, Tex., for duty.

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Dr. Henry Welsh Wickes, Passed Assistant Surgeon, U. S. A., class of 1892, has been commissioned a surgeon (recess), to rank as such from August 3, 1910.

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Dr. Lewis Mines Allen, class of 1896, presented a paper before the recent annual meeting of the Tri-County Medical Association, consisting of Jefferson, Berkeley and Morgan counties, held at Harper's Ferry, W. Va., September 7.

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Prof. R. Tunstall Taylor spent the month of August at Blue Ridge Summit.

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Dr. Edwin B. Fenby, class of 1878, of 1219 North Caroline street, Baltimore, is a guest in Providence, R. I.

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Dr. J. Lee Hopkins, class of 1897, of Havre de Grace, headed a committee from that city on a visit to the Union Hospital of Elkton, Md., for purposes of inspection and to gather data pertaining to its management and maintenance. Dr. Hopkins is urging the erection of a hospital in Havre de Grace.

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Drs. Thomas A. Ashby, class of 1873, and John S. Fulton, class of 1881, were the principal speakers at the annual meeting of the Cumberland Valley Medical Association, held at Blue Mountain House, Pen-Mar, September 1, 1910.

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Dr. James M. Craighill, class of 1882, has returned from a month's visit to Canada.

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Dr. Hiram Woods, class of 1882, has been the guest of friends in Boston.

---

Drs. Albert H. Carroll, class of 1907, and Harry A. Naylor, class of 1900, are interested in a move-

ment to promote the sanitary, educational and moral improvement of Hampden.

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Dr. John Watkins Williams, class of 1906, is located at Everettts, N. C., and is enjoying a large practice.

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A letter from Dr. John Perry Young, class of 1894, of Richburg, S. C., says: "I always enjoy the visit of the HOSPITAL BULLETIN."

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Miss Alice F. Bell, class of 1906, University of Maryland Training School for Nurses, has been appointed superintendent of that school.

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Miss Ravenell, a graduate of the University of Maryland Training School for Nurses, has been reappointed in the relief association in Aiken, S. C.

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Miss Ruth R. Kuhn, class of 1905, University Hospital Training School for Nurses, has been appointed a nurse in the Navy Nursing Corps. She has been stationed at the Naval Hospital, Washington, D. C.

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## ENGAGEMENTS

Mr. and Mrs. Millard F. Wright of Calvary, Harford county, Maryland, have announced the engagement of their daughter, Miss Mary Emma Wright, to Dr. Granville Hampton Richards, class of 1908, of Port Deposit, Md. The wedding will be very quiet, and will take place early in November.

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## MARRIAGES

Dr. Jacob Wheeler Bird, class of 1907, of Sandy Spring, Md., and Miss Mary McIntire Wilson of Centreville, Md., were married at St. Paul's Protestant Episcopal Church, Centreville, September 7, 1910, by Rev. W. B. Stehl, assisted by Rev. Benjamin N. Bird of Philadelphia, a cousin of the groom. Dr. Bird was formerly assistant superintendent of the University Hospital, where he met Miss Wilson, who graduated in Philadelphia and came to the University Hospital as assistant superintendent of nurses. Dr. Bird is the son of

Mr. and Mrs. J. Irving Bird of West River, Md. Miss Wilson is the daughter of Mrs. John Emory Wilson of Centreville, Md. After the first of October the couple will be at home at Sandy Spring, Md.

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## BIRTHS

Dr. Henry McKee Tucker, class of 1899, of Raleigh, N. C., and Mrs. Tucker are receiving the congratulations of their friends upon the birth of a daughter.

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Dr. William E. E. Tyson, class of 1905, of 2574 Jefferson avenue, Detroit, Mich., and Mrs. Tyson are rejoicing over the birth of a daughter August 24, 1910. Dr. Tyson has been located in Detroit since September, 1909, and reports most encouraging progress. We further learn that the "mule and cart" of the cartoon days of his senior year at the University has given way to a Cadillac automobile.

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Dr. Robert Levis Mitchell, class of 1905, of 2112 Maryland avenue, Baltimore, and Mrs. Mitchell had born to them on August 17 a daughter, Miss Nancy Mitchell.

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## DEATHS

Dr. James Robert Crockett, class of 1891, of Burkes Garden, Va., died at the University Hospital, Baltimore, August 2, 1910. Dr. Crockett was born in 1866.

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Dr. Martin Luther Fitro, class of 1896, died at his home in New Martinsville, W. Va., August 12, 1910, from uremia. Dr. Fitro was 45 years of age.

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Dr. Frank Denton Gavin, class of 1874, died at his home, 16 E. Lafayette Ave., Baltimore, Wednesday, Aug. 24, 1910, from an infection of the throat contracted in May. Dr. Gavin was born in Sabrevois, Canada, July 18, 1854, the son of the rector of the English church at that place. His mother was Miss Stevens of New York city. He received his early education partly in Canada and partly in the United States. He graduated in medicine at

the University of Maryland in 1874, and shortly afterwards was appointed resident physician at the Church Home and Infirmary, which position he held for over 30 years. He resigned in 1908 to enter private practice. Under his management the Church Home grew to its present strength. Dr. Gavin married in 1889 Miss Georgie Ridgely of Baltimore, who survives him. He was for many years a member of the congregation of old St. Paul's Protestant Episcopal Church. He was buried from his home on Saturday, Rev. J. B. S. Hodges officiating. Burial was in Greenmount Cemetery.

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Dr. John W. Dashiell died at his residence in Princess Anne, Md., Sunday morning, September 4, 1910, aged 93 years. Dr. Dashiell was a graduate of Kenyon College of Ohio, class of 1839, afterwards entering the University of Maryland, from whence he graduated in 1843. He then took up the practice of medicine at Vienna, Md., and remained there until 1847, when he returned to Somerset county. He was married in 1852 to Miss Eliza Polk, who died in 1897. He is survived by two daughters, Mrs. Francis H. Dashiell and Mrs. E. Orrick Smith, both of Princess Anne. Dr. Dashiell was buried from St. Andrew's Protestant Episcopal Church, of which he had been a vestryman for more than half a century.

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Dr. Marshall J. Brown, class of 1907, of Greensboro, Caroline county, Maryland, was found dead in his room at the New Howard House, Baltimore, at an early hour Sunday morning, September 4, 1910. It is supposed that he died from an overdose of chloral hydrate, taken for medicinal purposes. He was the son of Rev. Amos R. Brown of Cecil county, Maryland. After graduation Dr. Brown practiced for a time near Westminster, Md., afterwards locating in Greensboro. He had been unwell for the past 10 days, and was on his way to visit his parents at Sylmar. He was buried on Wednesday afternoon in Rosebank Cemetery, Cecil county, Maryland.

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Dr. John Morgan McLaughlin, class of 1888, of Webster Springs, W. Va., died at a hospital in

Clarksburg, W. Va., August 19, 1910, from typhoid fever. Dr. McLaughlin was born in 1860. He was a member of the American Medical Association.

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Dr. Frank Camm, class of 1885, died at Lynchburg, Va., August 5, aged 62 years. Dr. Camm was a member of the Medical Society of Virginia, and was assistant surgeon at Camp Alger during the Spanish-American War.

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## BOOK REVIEW

**REFRACTION AND HOW TO REFRACT.** James Thorington, A.M., M.D. P. Blakiston's Sons & Co., publishers, Philadelphia, Pa. Price, \$1.50 net.

This volume of 324 pages is now in its fifth edition. Its popularity is shown by the fact that there is now in preparation a translation in Chinese.

This edition has been revised and numerous new plates added. The text is concise, free from many mathematical formula, and from the first chapter, which has to do with optics, one is led by degrees to the more difficult problems in refraction. The most interesting chapter is the ninth on "How to Refract." In this one is given the various steps in refraction, thereby making it unusually easy to comprehend the methodical way an oculist refracts.

Chapter II is devoted to series of cases of Ametropia, the results obtained and their prescriptions.

The chapter on Presbyopia is brief and not difficult for a tyro to understand.

The last chapter is devoted to the taking of measurements for spectacles and nose-glasses, a very important part of the refractionist's work, and especially useful to those so situated that they cannot refer their patients to the prescription optician direct.

All in all, considering the effort to be made by medical schools to encourage its students in refraction work, this book is a valuable contribution.

We can heartily endorse it,

# THE HOSPITAL BULLETIN

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Vol. VI

BALTIMORE, MD., OCTOBER 15, 1910.

No. 8

## HEMORRHAGE.

*Abstract of Lecture Delivered at the University of Maryland by Randolph Winslow, M.D., LL.D., Professor of Surgery, University of Maryland.*

Hemorrhage is usually the result of injury, but in some instances may be spontaneous. Hemorrhage from different parts have different names. If from the nose it is called epistaxis; if from the lungs, hemoptysis; if from the stomach, hæmatemesis; if from the uterus, metrorrhagia, etc.

*Classification.*—According to the source of the blood hemorrhage is divided into four varieties—arterial, venous, capillary and parenchymatous. The symptoms vary with the vessels injured and with the size and direction of the wound.

*Arterial.*—Arterial, the most important, as it demands our promptest attention, is characterized by bright red blood spurting out in jets synchronously with each pulsation of the heart. In this variety of hemorrhage pressure upon the proximal side of the severed vessel will arrest bleeding. When the artery is only partially divided the bleeding may be continuous and not in jets. If anastomosis is free the bleeding will sometimes occur from the distal end. In this case, however, the stream is not pulsatile, but continuous, and both ends of the severed vessel should be ligated.

*Venous.*—Venous hemorrhage is characterized by a continuous stream of dark red blood flowing from the distal end of the severed vessel. Pressure upon the proximal side will increase the flow, upon the distal arrest it.

*Capillary.*—Capillary hemorrhage is characterized by an oozing from a wounded surface. The color of the blood depends upon the amount of cyanosis. If in an arterial portion it will be red.

*Parenchymatous.*—Parenchymatous hemorrhage is characterized by the fact that it occurs in those organs or portions of the body where the

terminal arteries empty into the terminal veins without the intervention of a capillary system, i. e., in the spleen.

Hemorrhage is divided upon another basis than an anatomical one, viz., a clinical one. It may be either primary, recurrent or secondary. Hemorrhage is said to be primary when it occurs immediately upon the receipt of the injury; recurring when it sets in after reaction has taken place, and secondary after a longer interval, usually after sloughing has occurred or when the ligature has ulcerated through the vessel.

*Constitutional Symptoms.*—Besides the local symptoms of external hemorrhage which are manifest to all there are certain constitutional phenomena which follow all severe hemorrhage. In internal or concealed the diagnosis must be made from the general symptoms. In slow bleeding exhaustion gradually and slowly supervenes; with each hemorrhage the patient faints and his life is preserved thereby. He becomes pale, faint, weak and giddy; his pulse is quick, irritable and feeble; his breathing is sighing, rapid and oppressed; the voice is low; the skin becomes pale, with a yellowish tinge; the mucous membranes are bleached, and often dropsy occurs. These symptoms may gradually pass off and health be restored, or death may ensue. If a hemoglobin estimate is made it will be found that this important constituent of the blood is considerably reduced. When a sudden hemorrhage of a large vessel occurs the pulse flickers or pulsations cease suddenly, the face is livid, the lips black and the skin cold. The patient faints and becomes unconscious. He is very restless, tosses about and sometimes is convulsed. He is in a cold, clammy sweat and may present air hunger. Death usually occurs when a vessel the size of the femoral is cut unless immediate measures are taken to arrest the hemorrhage.

*Natural Arrest of Hemorrhage*—(1) *Temporary.* (2) *Permanent.*—When an artery is cut,

first, retraction within its sheath occurs; second, a contraction of the vessel or diminution of its calibre; third, the blood coagulates in the sheath external to the cut end of the vessel; fourth, an internal coagulum forms up to the nearest anastomotic branch; fifth, plastic exudation, which seals the end of the artery and by its organization a permanent cure is effected. When an artery is torn the internal coats are ruptured in shreds and form valves or barriers upon which coagulation occurs advantageously.

*Treatment.*—The treatment of hemorrhage may be both local and constitutional.

*Local.*—In local treatment the first thing to do is to make pressure on the bleeding part. Position in some cases will control hemorrhage, i. e., a man has a hemorrhage from an ulcer on his leg, elevate the limb. In some cases the application of heat or cold will control the bleeding. Some styptics act mechanically and some by action on the blood. They are not much in use at the present day. The actual cautery is one of the best agents we have at our disposal to check persistent hemorrhage. When other remedies fail, adrenalin will sometimes control hemorrhage. Forceful flexion of a joint may stop hemorrhage below the articulation. Torsion is not to be used except on small vessels. In acupressure the needle is passed under the vessel and the ligature tied over the needle. Ordinarily the vessel should be ligated. Secondary hemorrhage is to be treated in the same way.

*Constitutional or General Treatment.*—When bleeding occurs from parts which cannot be reached, for example, the intestines, the best mode of procedure is to quiet the patient with morphia. Sometimes ergot, acetate of lead, tannin or suprarenal extract are administered internally with indifferent success. As a result of the anemia the patient should be put upon full doses of iron.

Venous hemorrhage is not so bad and should be treated with pressure, and the vessel will soon collapse of itself. Generally speaking, you should use the same measures as you employ for the control of arterial bleeding.

Capillary oozing is managed best by pressure upon the part or by the application of heat or cold. When these measures fail we then resort to the cautery.

## THE TREATMENT OF SYPHILIS WITH THE EHRLICH-HATA NEW ARSENIC PREPARATION, ESPECIALLY IN LESIONS OF THE NOSE AND THROAT.

By JOHN R. WINSLOW, M.D.,

*Clinical Professor of Diseases of the Throat and Nose, University of Maryland, Baltimore.*

While engaged in special study in Berlin during the past August, my attention was drawn by reports of sensational results, to this new anti-syphilitic treatment, and I believe that some short account of it would prove of interest to the readers of THE BULLETIN.

This remedy was produced under the direction of Professor Ehrlich of Frankfort-am-Main, and tested upon various animals by Hata; subsequently tests upon the human being have been made in increasing numbers.

The substance is a yellow powder, termed chemically Dioxydiamidoarsenobenzol, or 606 for short. Of this a solution is made with water, containing the single dose 0.3 gm., and injected into the gluteal muscles. There is seldom much local or general reaction, although at times slight pain and high temperature occur. Ehrlich affirms that given in the right way and with proper indications the remedy is free from dangers and does not induce any appreciable by-effects. He has the records now of over 3000 cases. In view of the toxic action of arsenic on the optic nerve, Spatz advocates an examination of the eye fundus in every case, and that the injection be made only in normal cases.

The preparation is effective in all of the infectious forms of syphilis. The spirochetæ are destroyed, sometimes within 24 hours, and in other cases after several days. The Wasserman reaction usually disappears within 8-40 days.

The results of the injection of a single dose (0.3 gm.) of the remedy, as recorded by various observers, are striking, and at times almost incredible. At times the results are so rapid that after a few days there is nothing more to be seen of the lesion.

The initial lesion (chancre) becomes clean and heals in a few days. Dorr of Vienna recently records a number of cases of chancre which were injected before the secondary stage, and which

were investigated for spirochetae and the Wasserman reaction. These rapidly disappeared. Anginas, with a smearable coating, generally so obstinate, undergo rapid resolution.

Mucous patches of the mouth and tonsils heal in 24-48 hours, even if the patient is an inveterate smoker.

Gummata of the mouth and throat disappear rapidly, even when ulcerated.

Syphilitic growths of the larynx, attended with dyspnoea and stridor, disappeared after two injections.

Syphilitic ozena was remarkably benefited.

Wechslerman records the following case, which he himself designates as "incredible":

A patient, who seven months previously had acquired syphilis, had received 35 salicylate of mercury and calomel injections. For past three months has had rheumatism of knees; he was pallid and emaciated, with a facial expression like a death's head. On the face and body were ulcers the size of a ten-cent piece covered with crusts. A foul odor emanated from the nose, in which the septum was perforated, and the left inferior turbinal and the vomer were necrotic. Marked pain on swallowing, so that the patient must be fed by means of the esophageal sound and nutrient enemata. Pulse small, compressible and over 120. Injections of iodopin proved useless; 0.4 Ehrlich-Hata were injected; no elevation of temperature; moderate pain. In 2-3 days the general condition markedly improved, and in 5 days general healing began.

The diseased bony nasal skeleton was completely exfoliated, and the fetor disappeared. On the ninth day the ulcers were completely healed, and on the sixteenth day the patient began to swallow and his body weight began to increase.

Michaelis records a case which, despite treatment for a year with mercury, potassium iodide and atoxyl, developed ulcers of the palate, right and left from the uvula, and a saddle nose, the uvula hung only by a thread and was expected to fall off any day.

On the third day after injection the edge of the ulcer became more healthy, and on the eighth day the ulcers were almost healed.

Equally remarkable results have been reported in other regions of the body than these in which I am especially interested.

We are not yet in a position to know in so short a time whether permanent healing, that is absence

of recurrence, is produced, or will be produced by higher doses.

Bearing in mind, however, the long known beneficial action of the older preparations of arsenic in this disease, even while discounting the enthusiasm and optimism associated with new remedies, we must admit that so effective a remedy as Ehrlich's new preparation has not hitherto existed, and that in it we have promise of the permanent cure of syphilis; even those refractory forms which do not react to mercury seem to yield readily to it.

The remedy will be placed upon the market about November 1, and its real value will be established by abundant clinical experience.

114 West Franklin street.

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## THE CARE OF THE EXCITED AND VIOLENT INSANE.\*

By HARRY D. PURDUM, M.D.,

*Physician-in-Chief Insane Department, Bayview Asylum.*

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For the sake of brevity and clearness, I propose to divide the subject-matter into three arbitrary groups—the mildly excited or hypomania, the intensely excited or mania, and the violently excited or states of furor.

**Patients suffering from mild excitement or hypomania:** Commitment may be neither indicated nor justified. Indeed, under such circumstances, commitment is frequently objected to by the relatives. The lucidity of these patients is, as a rule, perfectly preserved, and it is only at times when the excitement attains an unusual intensity that commitment becomes necessary.

The majority of these cases, with judicious handling and care, can be treated during the entire course of the disease outside of an institution for the insane. The special plan adopted, of course, will depend entirely upon each individual case and the circumstances surrounding it.

When the attending physician decides upon extra-mural care, the first step taken should be to procure a good nurse—one who is tactful, intelli-

\*Read before the semi-annual meeting of the Medical and Chirurgical Faculty of Maryland at Annapolis, September 14, 1910.

gent, physically strong and even-tempered. The next step should be toward isolating the patient from all forms of excitement, members of the family and the immediate circle of friends. Much harm is done by the association of the patient with his relatives, because their mere presence is a constant reminder of his changed condition, and accentuates his excitement.

Isolation may be attained by removing the patient from his home to some quiet private hospital or to a house in the country. In selecting a room, the physician should have in mind one which is free from noise and all sources of mental and emotional excitement.

Direct communication with the outside world during the first few weeks should be cut off; if not altogether, at least in a great measure.

Under correct conditions the benefits derived from isolation and rest in bed are both mental and physical. The nervous tension and exciting causes are withdrawn, and the physical strain is likewise reduced to a minimum. The external excitants having been removed, the mental expenditure is reduced to a slight play of the emotions and an easy drifting of the thoughts—a condition which soon breeds placidity and in most cases early recovery.

The treatment of mildly excited cases from now on consists essentially in the application of physiologic methods as far as practicable.

The patient can frequently be prevailed upon to go to bed at the outset by a little tactful management on the part of the nurse, and then, with the judicious and occasional use of sedatives, the rest in bed can be continued over a sufficiently long period.

The diet in these cases should be systematic, easily digested and highly nutritious. Milk should be given with meals, between meals and at bed-times, and in as large quantities as the patient can take and digest. Full feeding is absolutely essential.

In these cases of mild excitement, wherever treated, it is necessary to allay as far as possible, the excitement and insomnia from which the patients suffer. Whenever practicable, we should endeavor to accomplish this by some form of hydrotherapeutics. Warm sponge bathing, between blankets; the warm pack, or the continuous warm bath may be instituted with great benefit.

The physician should constantly keep in mind the low blood pressure, the sluggish cerebral circulation and the defective elimination, more or less constantly encountered in this particular form of the so-called functional psychoses, and treat them accordingly.

Usually it is best to bring the patient under the influence of some sedative before attempting any radical procedure of hydrotherapy, as he very often resists handling of all kinds, and it is only after the administration of a sedative that baths can be instituted without the serious risk of exhausting the patient by useless struggling.

While giving a warm bath or pack, cold towels or a specially made ice cap should be applied to the head.

Gentle massage should be practiced daily, providing the excitement is not intensified.

Electricity should never be used during the early stages of the disease on account of its exciting influence on the patient.

Because of the duration of these mildly excited or hypomanical cases caution is to be exercised in regards to the prolonged use of drugs. They should be regarded largely as emergency remedies, and so far as practicable they should be varied from time to time.

I have gotten fair results by using an occasional powder consisting of equal parts of sulphonal and trional. While these drugs act slowly, one can usually foretell when a sedative will be required.

Hyoscin is a potent drug, but when given by the mouth is very unreliable and often useless. When administered hypodermically, the prick of the needle frequently accentuates the excitement, though one is often driven to this method of administration by a patient who is much excited and refuses medication by mouth.

Ergot should not be forgotten in treating these cases, because its power to increase the blood pressure is often of great benefit.

The efficiency of paraldehyde in overcoming sudden and intense excitement should not be overlooked, but its unpleasant taste proves a serious obstacle to its use. Whiskey affords a convenient vehicle for its administration and one that is often acceptable to the patient.

The various bromides, chloral and many combinations may be used with good results.

When recovery is approaching, sleep becomes

more restful; there is a gradual gain in weight, and the psycho-motor activity subsides. At this stage the patient should be gotten out of bed, given graduated exercise and gradually introduced to the outside world. Complete recovery now soon follows.

The intensely excited, or so-called cases of mania: Commitment is advisable at the outset, because of the great psycho-motor activity, clouded sensorium, rapid exhaustion and the lack of experience on the part of the general physician in treating these cases. A hospital for the insane should be selected which has a complete continuous-bath apparatus and well-trained nurses, as both are very essential.

Time forbids me going into details, but I might say that these cases should be specialized at all times by an experienced, well-trained nurse, and that the continuous bath should be used to quiet them and promote sleep. Aside from this, the diet and general treatment should be the same as the first group, having in mind at all times the low blood pressure and the rapid waste and exhaustion.

When these cases of intense excitement begin to recover, they often entertain delusional ideas based on false perceptions conceived during the excited period, and if overlooked and not corrected by the nurse or attending physician, become fixed delusions of persecution.

I am inclined to think that many of the patients suffering from chronic mania, with delusions of persecution, found in our asylums are such neglected cases, and had they received psycho-therapeutic treatment at the proper time would have recovered.

The two groups just considered include only the excited states of manic depressive insanity.

The third group includes cases of violent excitement or states of furor. This form comes on, as a rule, suddenly, and is usually associated with epilepsy or paresis.

The best treatment is to overpower and restrain the patient, place an ice cap to his head and administer hyoscine hypodermically, and croton oil by mouth. If an epileptic, commitment may not be necessary, because the duration of such an attack is short, and with proper treatment the patient may never have another; but if a case of paresis, commitment is indicated at once.

## CYST-ADENOMATA, WITH REPORT OF A CASE.

By EDGAR SHIRLEY PERKINS, M.D.

In reporting this case of cyst-adenoma, there is nothing new or original, except the fact of the size of the tumor. Large tumors, which were frequently reported in former years, are rarely seen now, because they are removed early. The case I have to report was a patient who lived in the country away from surgical assistance, and the growth was very rapid. Before giving the history of the case we will look into the genesis of these cysts.

Cyst-adenomata owe their origin to the multiplication of some glandular elements in the ovary. It may originate from the lining of the Graafian follicles, as Pfannesteil and Gibbard believed; or as claimed by Walthard, from germinal epithelial rests, or from Muellerian structures. The true origin is not definitely known.

The etiology is not positively understood. It may be the result of either of the following causes:

1. Infection which will take place through the tube.
2. Through the lymphatics.
3. Traumatism.
4. In ovarian cysts, the appendix usually presents evidence of chronic inflammatory changes.

These cysts are usually unilateral, occurring more often on the right side, but may occur in both ovaries at the same time. They are found at all periods of life, but most frequent between the ages of 16 and 45 years, i. e., during ovulation. A case has been reported by Kelly of the removal of a cyst, the size of a cocoanut, from a child five years old, the child having had some pain, a vaginal discharge of blood, and gave a history of a fall three years previous to the time of the operation.

Ovarian cysts are found in all classes of women, but more frequently in the white race.

*Varieties.* — 1. Adeno-cystomata. 2. Cystic papillomata. 3. Dermoid cysts. 4. Par-ovarian cysts. 5. Cysto-sarcoma. 6. Cysto-carcinoma.

*Size.* — They vary greatly, some huge masses weighing upward of 100 pounds, while others are the size of an orange.

The cyst walls are from 2 to 6 mm. in thickness,

and consist of a firm, fibrous tissue. Frequently large, dense, fibrous plaques are found on the outer surface; sometimes large calcified areas. The inner cystic septa are usually very delicate and transparent, and less than 1 mm. in thickness. The inner surfaces of both the large and small cysts are smooth and glistening.

*Color.*—They appear as round or oval masses, with smooth and glistening surfaces, irregular in outline, and present many large or small cysts. The walls are pearly white or may be slightly bluish or pinkish in color. Beneath the external layer, which is composed of a serous membrane corresponding with the peritoneum, we find numerous blood vessels, which can be seen radiating from the main trunks at the pedicle. The middle coat is composed of connective tissue, in which are found blood vessels that feed the cyst. The inner coat is lined by a single layer of cylindrical epithelium, which is often ciliated. Some of the cells are swollen and filled with clear contents, resembling goblet cells. The cysts may be filled with a serous fluid of amber color, gray, reddish-brown, dark brown or chocolate color, the color depending upon the hemorrhages that have taken place in the cystic cavities. The specific gravity of the fluid varies from 1010 to 1030, and contains much albumen. The microscope reveals desquamated fatty epithelium; also large cells which are filled with yellowish pigment, which probably originate from the epithelium.

The fluid which is present in these cysts has its origin from three sources: (1) The secretion from the epithelial cells; (2) the transudation of serum from the blood vessels; (3) and the destruction of cells.

Pseudo-mucin is one of the most important of the constituents of the glandular ovarian cystomata, and is characteristic. Para-albumin and meta-albumin have been identified with the cystic contents, which, however, have been altered as shown by O. Hammerstein, who also shows that they do not belong to the albumin group, as was first supposed. Para-albumin is not a chemically pure body, while meta-albumin, on the other hand, is closely allied to mucin; and to avoid confusion, Hammerstein gave it the name "pseudo-mucin." Pfannenstiel applies the term "glyco-proteid," because it splits up into an albumin and a sugar.

Formerly by some authors ovarian cystomata were known as "colloid cysts," because it was believed that the cyst contents were of a colloid

nature. They are, as a rule, of a mucous-like substance, now known as pseudo-mucin, but they are sometimes of a true colloid character. Some cysts contain a yellowish, transparent, jelly-like material, which is slightly tenacious, while others contain a yellowish-white, semi-transparent viscid fluid. The fluid elements largely predominate—water, 93 per cent.; organic elements, 6 per cent., and inorganic elements, 9-10 per cent.

*Pedicle.*—The pedicle varies in length and size, and is made up of folds of peritoneum, tube and blood vessels supplying the ovary, and connective tissue in which are the nerves and muscle fibers. Tortion of the pedicle sometimes takes place and is recognized by sudden and severe peritoneal symptoms—severe pain, vomiting and rise of temperature.

*Complications.*—Tortion of the pedicle, adhesions between the cyst and adjacent viscera, inflammation and suppuration of the cyst, and degenerative changes in the cyst walls.

*Symptoms.*—In the early stages no symptoms are noticed, but occasionally a small tumor may produce unpleasant symptoms, such as pain in the sacrum and extending down the leg. In large tumors distress arises from pressure and interference with the circulation and respiration; the skin becomes stretched and forms striae; swelling of the navel; hernia; occasionally from pressure upon the great vessels, edema, varicosities in the legs, in the sexual apparatus, and in the skin of the abdomen; albuminuria; diminished amount of urine, and compression of the renal veins are observed. Menstruation is usually unaffected. Amenorrhea may exist for several years, and menstruation may return after the removal of an ovarian cyst.

*Diagnosis.*—Usually made from the physical signs. First, we consider if we have a tumor. Second, we must consider if this tumor is an ovarian tumor. Third, if it is an ovarian tumor we must ascertain its relations to the surrounding parts. The existence of a pedicle and adhesions are to be considered.

Cystic tumors must be diagnosed from the following:

1. Desmoid tumors of the abdominal wall.
2. Ventral hernia.
3. Fecal accumulation in the colon.
4. Distended bladder.
5. Ascites.
6. Pregnancy.

7. Hydramnios.
8. Extra-uterine pregnancy.
9. Uterine myomata.
1. Desmoid tumor in the abdominal wall occurs in the muscle, are quite movable, superficial and hard. Its situation in the wall, its density and failure to recognize by vaginal or rectal examination any connection with the pelvic viscera should determine its character.
2. Ventral hernia.—The recognition of the coils of intestines and the peristaltic action through the thin abdominal walls are usually sufficient.
3. Fecal accumulations occur in the colon or transverse portion of the gut, which may descend and lie directly over the pelvis. The accumulations are occasionally quite extensive, but are recognized by their length, by the peculiar sensation under palpation, and, most of all, by the fact that they disappear with purgatives and enemas.
4. Distended bladder causes symptoms of a tumor in the lower part of the abdomen, which fluctuates, and may readily be mistaken for an ovarian cyst. The suspicion is confirmed by the history that the patient is passing urine in small quantities, or that it is continually dribbling. This, however, should make us suspicious, and the introduction of a catheter into the bladder will clear up the diagnosis.
5. Ascites.—In ascites the abdomen is more or less flattened, its widest diameter being transverse, while in ovarian cysts it is most prominent in the vertical diameter and narrow from side to side. On palpation ovarian cysts present greater resistance, and the outline of the surface is more distinctly determined. Percussion is most valuable; in ascites the zone of resonance changes with the patient; in ovarian cysts, on the contrary, there is dullness over the tumor, which does not vary with the position of the patient.
6. Pregnancy.—The enlargement of the abdomen is more rapid, is generally associated with suppression of menses and presence of sympathetic nervous phenomena. As pregnancy advances, foetal movements are heard; also the foetal heart-beat, and parts of the foetus are recognized. Foetal heart sounds, when heard, are characteristic.
7. Hydramnios is a pathological form of pregnancy in which a large collection of fluid occurs in the uterine cavity. Hydramnios comes on suddenly, about the sixth or seventh month of pregnancy, which has previously run a normal course.
8. Extra-uterine pregnancy, sufficiently large to permit it to be confused with an ovarian cyst, will present the symptoms of an early pregnancy, possibly indications of a rupture of the sac, and internal hemorrhage. The diagnosis is determined by careful analysis of the objective symptoms associated with a thorough physical examination.
9. Uterine myomata are slow in growth; there is more resistance; the presence of multiple growths, irregular contour, and the relations to the uterus afford confirmation in the diagnosis.
- The case that I have to report occurred in a white woman, aged 57 years, and who had been married 37 years. The patient came to the hospital on August 12, 1907, suffering with much distention of her abdomen and great pain in the lower portion of the abdomen. The enlargement was first noticed nine weeks previous to entering hospital, and no pain until ten days ago, when she first noticed a dull pain, which soon increased and became very acute.
- Family history* negative, with the exception of three brothers, who died of tuberculosis; one of angina pectoris, and one sister living, who has locomotor ataxia. No family history of cancer.
- Past History*.—Patient has always been very healthy with the exception of childhood diseases.
- Menses appeared at 14 years of age, and were always very regular, but accompanied with pain. Patient has never borne children or had any miscarriages.
- Present History*.—Three years ago, in 1904, patient suffered with pain in the right ovarian region. She noticed a small lump in the appendicular region, which soon disappeared. She again noticed the swelling nine weeks before entering the hospital. Patient has always been very nervous, taking the form of fear and fright. Otherwise she has always been healthy.
- On August 13, 1907, the patient was taken to the operating-room and prepared for operation. An incision was made in the median line, cutting through the fibers of the right rectus muscle. Upon opening the abdomen it was found to contain over two gallons of a jelly-like substance of a dark yellow, and some of it of a pinkish color. This gelatinous material in the abdomen was the result of the rupture of a large right ovarian cyst. The gelatinous material completely filled the abdominal cavity and extended as far up as the

liver and diaphragm. The substance was transparent, and could be cut with a knife (jelly-like). After removing this substance the cyst wall of the right ovary was excised, and the stump of the cyst was then sutured and covered over with peritoneum. The appendix, which was also involved, was removed, and all adhesions were released and broken up.

The patient made an excellent recovery, and left the hospital in two weeks entirely well. I have heard from her in the past two weeks, and she says that she is in excellent health.

#### THE DORMITORIES FOR HOUSE STUDENTS.

One of the most characteristic and important features of the medical instruction at the University of Maryland for the past 40 years has been the opportunity offered to students to become clinical assistants, or, as they are usually called, "house students." By the payment of a fee, about equal to the yearly rental of a room in a boarding-house, students with the proper qualifications can become clinical assistants in the hospital, and witness and assist in the work of the institution. The number of those who avail themselves of this opportunity is constantly increasing, and is now up to the full capacity of the dormitory accommodation.

With the transference of the maternity wards from 622 West Lombard street to the new wards in the University Hospital, and the altering of the old students' building for nurses, the old maternity building was fitted up as a students' dormitory, and the house students are most comfortably domiciled therein. The house is large, well built, with spacious rooms, and an attractive yard for recreation, and is much better adapted for the purpose of a students' residence than any that we have had previously. Those who could not secure rooms in this building are located in the house on South Greene street, immediately in the rear of Davidge Hall, which is also filled to its utmost capacity. The training obtained by these resident students is of the greatest value to them, and it is to be hoped that the time is not far distant when the whole senior class shall be trained in

this most practical manner through an actual residence in the hospital.

#### THE NEW DORMITORIES FOR NURSES AT THE UNIVERSITY HOSPITAL.

For some time it has been evident that it would be necessary to provide new dormitories for the pupils of the Nurses' Training School. The old dormitory, erected in 1890, was intended to house about 30 pupils, which was a sufficient number for the needs of the hospital at that time. With the rebuilding and enlargement of the hospital the work increased to such an extent that accommodation for at least 70 nurses became imperative. This has been accomplished by remodeling the three houses situated to the west of the hospital, and known as Nos. 617, 619 and 621 West Lombard street. No. 621, which was formerly Mrs. Dawson's boarding-house, has been occupied by nurses for a year; and 617, formerly known as the Students' Building, and 619, have been extensively altered and made into most attractive homes for the nurses. Single rooms, heated with steam and lighted with electricity, are provided for each pupil, with the exception of a few double rooms equally provided with heat and light. Ample and commodious toilet and bath rooms are also furnished in each building, and large and pleasant recreation and class rooms, where the pupils may amuse themselves without disturbing the patients in the private rooms and wards of the hospital.

We are glad to announce, therefore, the completion of these most needed improvements, by means of which the health, comfort and happiness of the young ladies in training will be conserved.

The editors of *THE BULLETIN* are endeavoring to complete several sets of *THE BULLETIN* for various libraries. The following numbers are desired: July, 1905; January, 1907; March, 1908; June, 1909, and February and March, 1910. Anybody having the same and willing to part with them will be conferring a great favor upon us by notifying the office to that effect.

Dr. Samuel Jackson Price, class of 1909, has located at Queenstown, Queen Anne's County, Maryland.

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NATHAN WINSLOW, M.D., Editor

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## HOW TO STUDY MEDICINE.

In June of this year the fourth Bulletin of the Carnegie Foundation, dealing with medical education, was issued under the editorship of Abraham Flexner, a non-medical man, and with the authorization and commendation of Henry S. Pritchett, president of the Carnegie Foundation, also not a medical man. Whilst there is much that is untrue and exaggerated in this report, there is also much that is useful and true. This report was not only advertised most extensively in the secular press, with the intention of injuring many institutions of the highest respectability and usefulness, but in many of the magazines and journals of the land articles were published by Mr. Flexner with the same object in view. In these articles are many misstatements of fact, but these papers were accepted or solicited by the journals because it was supposed that an absolutely unbiased and authoritative presentation of medical conditions as they then existed was therein depicted. Notwithstanding the misstatements, the slurs on the medical teachers and schools, the insult to legitimate medicine by including osteopathic plants amongst medical colleges, the publication is full of interest and of considerable value. That there are too many medical schools is well known; and since the appearance of the report two institutions in this city have closed their doors, and others have done likewise in various parts of this country. In the *Outlook* for October 1 is an article entitled, "How to Study Medicine," from the pen of Mr. Henry S. Pritchett. This article is presumably based on

the Flexner report, and is also an absolutely incorrect statement of conditions existing in the legitimate medical schools of this country. Mr. Pritchett animadverts against the advertisements of medical schools, not recognizing, apparently, that the greatest advertisers are the very institutions that he mentions as exemplars of virtue. He says: "Many clerks in country stores and assistants in railway offices are lured to study medicine as a result of the alluring inducements held out by these advertisements, inducements which paint the life of the physician and surgeon in glowing colors and the receipts from professional fees in the most optimistic vein." The writer has no knowledge of any such institution, and believes the idea to be a figment of Mr. Pritchett's imagination. We also believe the physicians of the United States to be more prosperous, as a class, than those of any other country in the world, and that the overcrowding of the profession is more apparent than real. The production of physicians, like any other commodity, is largely determined by the law of supply and demand, and when the conditions depicted by Mr. Pritchett are reached, the output will rapidly decrease. As a matter of fact, fewer persons are studying medicine than formerly, and it is probable that the tide has reached its full and that the ebb has already begun.

He states several aphorisms which at least lack originality. First, medicine is a profession, not a business. The man who is seeking a business which will bring him money should look elsewhere. Alas, too true!

Second, no man should choose a school in which to study medicine through an advertisement, but find out from the best informed physician in your neighborhood where medicine may be rightly studied. We imagine most prospective students follow this rule.

Third, medicine has almost been made over in the last 20 years. Today the practice of medicine rests upon the application of certain fundamental sciences—physiology, anatomy, bacteriology, physiological chemistry, and the like. These facts are pretty well understood by physicians, and are very quickly instilled into students.

Fourth, he must be not only grounded in these fundamental sciences, but he must be an educated man as well. This statement, whilst not novel, is true; but what constitutes an educated man? Four years in college and an academic degree do

not guarantee a liberal education. Many men without college training are educated to a very high degree. Many, possibly most, of the greatest lights in the profession at this time are not graduates of colleges of liberal arts, and are, nevertheless, highly educated.

Fifth, the poor boy. The fact is that a poor boy has no right to go into the practice of medicine with any lower qualification than the rich boy. No man has a right to go into it unless he will fit himself fairly for the work. We have no quarrel with this statement; it is self-evident.

Mr. Pritchett speaks of ill-prepared medical schools which can live only by drawing to their doors a mass of uneducated and unfit men, the great majority of whom are turned out at the end of one or two years. There may be some osteopathic institutions in which this is done, but we do not believe there is a single recognized medical school in this country, regular, homeopathic or eclectic, where such a thing is possible.

The crux of Mr. Pritchett's advice as to how to study medicine is to go to a university medical school and not to a proprietary advertising medical school, and this leads to a question with which we will close: What is a proprietary advertising medical school?

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#### WOULD THE CONCENTRATION OF MEDICAL EDUCATION IN THE HANDS OF A FEW REDOUND TO THE BEST INTERESTS OF THE PROFESSION?

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An ukase has been issued that there are too many medical seats of learning in the United States; that there is an overproduction of physicians; that most of these institutions are foisting on the public men of inferior caliber; that the health of the public would best be subserved by the closure of two-thirds of these schools; that in cities where there is an overabundance of medical colleges these should be combined under one management. Sad to relate, these tenets and postulates sound well on paper, but actually they are woefully weak. If their consummation would really accomplish the desires of the men who broached them, medicine would be the gainer thereby. In all other lines of endeavor monopoly leads to stagnation and an assumption of arrogant self-satisfaction. In education, as in business, competition is the life of trade. Without this stimulus there would certainly be a retrogress-

sion in medical education. But let us look further. Has consolidation of schools in France been to the best advantage to the public and the profession? According to Sajous, than whom there is none better prepared to speak, limitation of the number of schools has not proven successful. Only a short while back during a visit to Paris he witnessed a result of the system now advocated in this country—the spectacle of the main courtyard of the Paris Medical School filled with troops, police and plain clothes men to preserve order during an examination for *agreges*, so intense was the feeling among the general profession and the students against a system which enabled the faculty to arbitrarily select whom they pleased for these positions. It is the boss system personified, even though the bosses here are high-classed men, who think, at least, they are serving the best interests of the school. In our country, Dr. Sajous thinks, the results of concentration would prove far more pernicious, for it is not the modest and learned scientist who would reach the apex of power, but the hustling, ignorant wire-puller. Briefly, France is chafing to rid herself of the very educational aristocracy with which idealists and dreamers hope to burden us.

But there is one side of the question which seems to have been overlooked by the advocates for reduction. These men assume that the function of a medical college is to produce experimenters; whereas, as a matter of fact, the chief function of a medical college is to educate young men to become practitioners of medicine. Students as a rule are neither capable nor prepared to do original lines of work; this should be left to post-graduates, as it is. There are two sets of men working in medicine—the experimenter and the practitioner. Both start with the same foundation, but after graduation one finds he is not temperamentally fitted to nor has the time nor money to engage in pure science. It is the function of the one to suggest and of the other to test practically these suggestions. A good experimentator may be a very poor practitioner, and, vice versa, a good practitioner need not be a well-equipped research worker. This dual rôle is the stumbling block of the medical reformer. He cannot conceive for one instant that a school which confines its endeavors to the production of doctors is fit to exist. In his mind, above all a modern doctor must be fully cognizant of the technique of the physiological, bacteriological, pathological and every other

sort of an ological laboratory. The methods of the laboratory are very nice to know, but it is not a requisite for the treatment of diphtheria to understand the exact procedure of the production of antitoxin; the important question to the doctor is the knowledge of how often, how and how much to use. It is very nice to know the technic of blood-counting, but to the practicing physician in a case of acute perforative appendicitis it is much more important to be able to diagnose the case by the clinical symptoms than to be an adept at blood-counting with no clinical knowledge. In other words, the laboratory is good in its place, but is not the whole of medicine.

Surely the system which produced such men as Oliver Wendel Holmes, Welch, Reid, Carroll, Councilman, Gross and others equally as illustrious has not been found wanting. The success of a system is the fruit it bears. According to this reckoning, our institution meets this test.

## ABSTRACTS

### NON-SPECIFICITY OF THE WIDAL REACTION.

Dr. H. W. Stoner, class of 1907 (*Maryland Medical Journal*, October, 1910), says it occasionally happens that complaint is received from physicians stating that the report of a specimen of blood sent to the laboratory for diagnosis of suspected typhoid fever was positive, whereas the subsequent course of the disease proved it to be some slight febrile trouble from which the patient recovered in a few days. That these complaints are not without foundation cannot be denied, and that such a report may at times cause great inconvenience to the patient or the family of the patient and embarrassment to the physician is likewise true. It is the object of his article to recall to the mind of the busy practitioner how such conditions may occur.

As is well known, the Widal reaction or serum diagnosis of typhoid fever is made by mixing equal parts of a 1 : 25 dilution of blood serum from the suspected patient and an 18 to 24-hour-old bouillon culture of *B. typhosus*, so that the resultant mixture will be a 1 : 50 dilution of the serum. Municipal and State laboratories use the Westbrook method, in which dried blood is dissolved in 100 times its weight of distilled water. Since blood loses three-fourths of its volume in

drying, this gives a dilution of 1 : 50. This is allowed to stand for one or two hours, at the end of which time, if clumping or agglutination of the bacteria has occurred, a diagnosis of typhoid fever can usually be made. This agglutination reaction is brought about by a certain constituent in the blood serum of patients with typhoid fever known as "agglutinin" combining with a certain element of the bacterial cell termed "agglutinogen."

That the action of agglutinin is special, but not specific, has been proven by many investigators, and while the agglutination of *B. typhosus* by the blood of patients with other infections is not common, it frequently occurs. It must be remembered that while a dilution of the blood serum of 1 : 50 has been found the best for an early diagnosis of typhoid fever, agglutination will take place at much higher dilutions, and sometimes at the height of the infection a positive reaction with a dilution of 1 : 2000 or even 1 : 4000 may occur. This not only applies to typhoid fever, but is true of other infections as well.

According to Ehrlich's side-chain theory, agglutinogen contains receptors of the haptophore group and agglutinin contains receptors of the zymophore group. The receptors of these two groups by combining bring about a chemical interaction resulting in agglutination. Durham believes that the receptor is not a compact, inseparable entity, but a complex body that may be split up into component parts, each of which may have independent action and exhibit individual structure. He has offered the following schematic explanation as to how one or more species of bacteria may be agglutinated by the same serum:

Serum constituents....	A, B, C, D, E, C, D, E, F, G, H, E, F, G, H, J, K.	B. typhosus.	B. enteritidis.	B. colon.
Bacillary constituents....	a, b, c, d, e.	e, d, e, f, g, h.	e, f, g, h, j, k.	

If the serum of a typhoid patient containing receptors of the zymophore group, A, B, C, D and E, is added to a typhoid culture containing receptors of the haptophore group, a, b, c, d and e, the maximum effect of clumping is produced, since all of the receptors of the agglutinin combine with all of the receptors of the agglutinogen. If the typhoid serum is added to a culture of *B. enteritidis*, only a certain proportion of the bacilli or their constituents will be affected, as only the receptors C, D and E of the zymophore group can combine with the receptors of the haptophore group of this organism. If a culture of *B. colon* is mixed with the serum, still less effect will be

produced, as there is only one receptor belonging to this organism capable of combining with the zymophoric group of the typhoid serum.

The factors C, D and E in this example are termed "group agglutinins" or "nebenagglutinins," because they possess the property of combining with receptors of both the typhoid and enteritidis bacilli. Thus in the schematic example above the "principle agglutinin" or "hauptagglutinin" of the *B. enteritidis* contains group agglutinins for both the typhoid and colon bacilli, and it is probable that all blood serums contain group agglutinins for many bacteria in greater or less extent.

Following the above example, the writer assumes that in the serum of a patient infected with *B. enteritidis* the receptors C, D, E, F, G and H of the zymophore group, combining with the receptors c, d, e, f, g and h of the haptoptophore group, will cause an agglutination of the enteritidis bacillus at a dilution of 1 : 200. If this serum is added to a culture of *B. typhosus*, the zymophore receptors C, D and E of the *B. enteritidis* will combine with the haptoptophore receptors c, d and e of *B. typhosus* and should cause an agglutination of this organism at a dilution of 1 : 100. If the serum of a patient infected with *B. colon* would agglutinate this organism at a dilution of 1 : 300, the same serum would probably cause clumping of *B. enteritidis* at a dilution of 1 : 200 and of the typhoid bacillus at a dilution of 1 : 50.

Durham has pointed out that even further complications may be caused by the number of different receptors in different strains of the same organism. For instance, in two different strains of the typhoid bacillus the receptors of one strain may be 10a, 5b, 3c, 2d and 1a, whereas in the other strain they may be 1a, 2b, 3c, 5d and 10e. It is only reasonable to suppose that these respective strains will cause agglutination at the maximum dilution of their component serums, and this may explain why different strains of *B. typhosus* and other organisms give agglutination of the same serum at different dilutions.

The presence of group agglutinins in a serum can be proved by the saturation experiment first performed by Bordet. If two portions of a serum that possess the property of agglutinating two species of bacteria, which we shall designate as organism A and organism B, are saturated with the respective organisms, the portion containing the "principle agglutinin" saturated with

organism A will no longer cause a clumping of organism B, because all of the receptors A, B, C, D and E of the zymophore group will have combined with the receptors a, b, c, d and e of the haptoptophore group, but the second portion of the serum saturated with organism B will still cause an agglutination of organism A at a lower dilution than formerly, since only the group agglutinins C, D and E have combined with organism B, leaving the receptors A and B of the serum to combine with organism A.

From the above it will be seen that the blood of patients with typhoid fever will not only agglutinate the typhoid bacillus, but may also cause clumping of other organisms; likewise the blood of patients suffering with other infections may sometimes cause agglutination of the typhoid bacillus. Indeed, Collins has produced agglutinins for *B. typhosus* by injecting animals with brewer's yeast, diastase, pancreatin, invertin, nuclein, mercapton, phenol, aleuronat, sulphur and phosphorus. The serum of a young goat inoculated with brewer's yeast that before injection agglutinated the typhoid bacillus at a dilution of 1 : 10, after the eighth inoculation caused a clumping of this organism at a dilution of 1 : 100. The same serum before inoculation caused agglutination of *B. dysenteriae* (Flexner) at a dilution of 1 : 20, and after the eighteenth injection clumping occurred at a dilution of 1 : 1000. An absorption test of the serum showed that all of the agglutinins were removed by saturation with the dysentery bacillus, and about 95 per cent. were removed by saturation with *B. typhosus* and a culture of the yeast with which the animal was inoculated.

The following cases of heterologous agglutination with the typhoid bacillus have been selected from the literature:

*Malaria Fever*.—Villiez and Battle obtained agglutination of bacillus *typhosus* with the blood from a case of malarial fever.

*Paratyphoid Fever*.—In a series of 42 cases of paratyphoid fever Muller and Graf found that the blood of 14 agglutinated both the paratyphoid and typhoid bacilli, the latter usually at lower dilutions.

*Typhus Fever*.—Wilson tested the blood of patients with typhus fever for agglutination with *B. typhosus*, and obtained a positive reaction in 18 out of 31 cases at a dilution of 1 : 50. Several of these were also positive at a dilution of 1 : 100.

*Chlorosis.*—Kohler has found that the blood of patients suffering with chlorosis occasionally gives a positive reaction with the typhoid bacillus.

*Icterus.*—In 1892 Jäger described an organism of the proteus group, *Proteus fluorescens*, as the cause of acute infectious jaundice (Weil's disease). His views are now generally accepted, and the blood of patients suffering from this disease frequently but not always agglutinates the typhoid bacillus.

Zupnik found that the blood of patients with Weil's disease frequently agglutinated *B. typhosus*.

Eckardt obtained agglutination of the typhoid bacillus with the blood from a number of patients with infective jaundice; in two of the cases at a dilution of 1 : 1000.

Ludke tested the blood of two patients with this disease, and found that both agglutinated the typhoid bacillus at a dilution of 1 : 20.

*Staphylococcus and Streptococcus Infections.* Lommel obtained agglutination of *B. typhosus* at a dilution of 1 : 80 with the blood from a case of puerperal fever.

White and Pakes, in a case of streptococcal endocarditis, obtained agglutination of *B. typhosus* at a dilution of 1 : 200.

Megele obtained agglutination of the typhoid bacillus with the serum of a patient with abscess of the liver from which staphylococcus aureus was secured in pure culture.

Lubowski and Steinberg report two cases of mixed staphylococcus and proteus infection of the mastoid cells, in which the serum from both patients agglutinated the typhoid bacillus, one at a dilution of 1 : 40 and the second at a dilution of 1 : 80. The proteus associated in the infection was agglutinated in both cases at higher dilutions than the typhoid bacillus.

Joehman reports a case of mixed streptococcus and *Proteus vulgaris* infection of the mastoid, with sinus thrombosis and general sepsis, in a patient whose serum agglutinated the typhoid bacillus at a dilution of 1 : 160. The proteus was agglutinated at a dilution of 1 : 640.

Graf found that the blood of a case of streptococcal septicemia agglutinated the typhoid bacillus at a dilution of 1 : 100.

*Pneumonia.*—Kassel and Mann, in two cases of croupous pneumonia, found that the blood agglutinated the typhoid bacillus at a dilution of 1 : 50.

Iversen describes a case of pneumonia occurring in a patient 21 years of age. Agglutination tests were made with *B. typhosus* on the eleventh and thirteenth days of the disease with negative results. On the sixteenth and nineteenth days, however, the reaction was positive at a dilution of 1 : 500, and on the twentieth day at a dilution of 1 : 1500, and also at the same dilution with serum taken at post-mortem. At autopsy diphtheria bacilli and streptococci were found in the throat, and the latter were cultivated from the spleen, liver and tonsil. The lungs contained the pneumococcus and showed croupous pneumonia. There was no anatomical nor bacteriological evidence of typhoid fever.

*Meningitis.*—Van Oordt obtained agglutination with *B. typhosus* with the serum from a case of endocarditis and meningitis due to the pneumococcus at a dilution of 1 : 40.

Jez obtained a positive reaction with the typhoid bacillus in a case of tuberculous meningitis at a dilution of 1 : 100.

Marcuse also reports a case of tuberculous meningitis the serum of which agglutinated the typhoid bacillus at a dilution of 1 : 100.

Symmers and Wilson report 21 cases of cerebrospinal fever in which the serum was tested with the typhoid bacillus and agglutinations obtained in seven cases—in three at a dilution of 1 : 50, in three at a dilution of 1 : 200, and in one case at a dilution of 1 : 400. One of these cases, the blood of which was positive on three different occasions at a dilution of 1 : 200, with two different strains of typhoid bacilli, came to autopsy. The meningocecum was recovered in pure culture from the purulent material of the brain and spinal cord, while numerous cultures from the spleen, mesenteric glands and urine were negative for the typhoid bacillus.

*Tuberculosis.*—Iversen has reported three cases of pulmonary tuberculosis giving positive reactions with *B. typhosus* at dilutions of 1 : 250, 1 : 250 and 1 : 50, respectively.

Krencker, in the examination of the serum from 26 cases of tuberculosis, obtained agglutination of *B. typhosus* in eight cases at a dilution of 1 : 50, and three of these were positive at a dilution of 1 : 200.

Stengel and Kneass obtained positive reactions in 22 out of 1387 examinations of non-typhoid serums.

Symmers and Wilson isolated an organism from

Belfast water which agglutinated antityphoid serum at a dilution of 1 : 50. This serum agglutinated the typhoid bacillus at a dilution of 1 : 1000.

Frost has isolated from Washington (D. C.) tap water an organism which he calls *Pseudomonas protea* which agglutinates the blood of typhoid patients at a dilution of 1 : 320.

The author has endeavored to explain why the serum of non-typhoid patients may sometimes cause agglutination of the typhoid bacillus, and has cited numerous instances of this phenomenon, but sometimes the blood of patients with typhoid fever fails to agglutinate the infecting organism, or clumping does not occur until late in the disease.

Stengel and Kneass found the Widal reaction negative in 109 out of 2392 cases of typhoid fever.

McFarland made daily tests of the blood of 230 soldiers ill with typhoid fever during the Spanish-American War, and was unable to get the reaction in 10 cases. Of 219 cases that were positive, 126 gave agglutination before the eighth day of the disease, 36 did not give the reaction until the second week, 45 were not positive until between the seventeenth and twenty-first day, 8 not until the twenty-fifth day, and 2 as late as the twenty-eighth day of the disease.

Block and Gwynn found the reaction negative in seven out of 151 cases. In only 26 was the reaction positive before the seventh day of the disease, and in four cases it developed on the twenty-second, twenty-sixth, thirty-fifth and forty-second day, respectively.

The writer states a number of such cases have been reported to the laboratory of the Subdepartment of Health, among others a particularly striking one in which the reaction was not positive until the sixty-first day after the patient was convalescent.

Ehrlich has shown that diphtheria toxin on standing for some time loses a part of its toxicity, but its affinity for antitoxin is undiminished. He believes that the toxin is not a simple unit, but is composed of two portions, one a combining or haptophore group, which is able to unite with the corresponding antitoxin, and a specific toxophore group, to which the poisonous action is due and a portion of which is destroyed by exposure to air and light. When the atom of the toxophore group is destroyed, the remaining combining atom of the haptophore group is known as a toxoid.

In explaining the non-agglutinating action of typhoid serum with *B. typhosus* the theory has been advanced that agglutinin, like toxin, may be composed of two parts—a zymophore or combining group and an agglutinin atom. It is supposed that the agglutinin may degenerate or be destroyed by certain chemicals or heat, and the resultant combining portion of the molecule is known as an "agglutinoid." These agglutinoids may combine with the receptors of the agglutinogens and thereby interfere with or block the agglutination reaction. The presence of agglutinoids has never been demonstrated, and there is doubt as to their actual existence.

A second and more generally accepted theory is that agglutination will not occur in the absence of certain mineral salts, and that the same laws that govern the precipitation of colloids in suspension apply to the agglutination of bacteria. It is probable, therefore, that in a small proportion of cases of typhoid fever the absence of certain salts from the serum inhibit or retard agglutination of the infecting organism.

Further on he says it is not intended in his article to cast disparagement on the Widal reaction as an aid in the diagnosis of typhoid fever. On the contrary, he freely admits that it is one of the most valuable assets in differentiating typhoid from other febrile diseases, and the employment of the test is urged whenever occasion arises. However, the laboratory can only report facts and conditions as they are found, and the laboratory findings should be regarded as an aid only in the diagnosis of a disease. The laboratory has its uses and its limitations, and the physician should regard it as a help in making his diagnoses rather than as a court of last resort. Interpretation of the laboratory report should be guided by the symptom-complex as observed at the bedside, and careful study and examination of the patient should always govern the diagnosis.

And again, the Health Department (Baltimore) has recently introduced the use of "blood-culture outfits" as still another aid to physicians in the early diagnosis of typhoid and other febrile diseases. These outfits contain the aluminum box and cover glasses found in our regular typhoid outfits, and besides they contain a tube of bile for collecting blood for the diagnosis of typhoid and paratyphoid fever or for urine and feces of suspected carrier cases. It frequently happens that

when the Widal reaction is negative we are able to isolate the infecting organism from the bile tube. This is particularly true in early cases of typhoid fever, and out of 42 positive blood cultures, two were obtained on the second day of the disease, four on the third day, six on the fourth day, and three on the fifth day of the disease. Twenty-two, or 51 per cent., of the cultures were positive during the first week. Besides, other infections are frequently diagnosed by this method, and paratyphoid and pyocyanus bacilli have been isolated on a number of occasions. It is not intended that the blood-culture method shall replace the ordinary Widal method in the diagnosis of typhoid fever, nor is it claimed that we are always able to isolate the organism from the blood, as it frequently happens that a positive Widal reaction is obtained while the blood culture is negative; but as an adjunct to the Widal outfit we are sure it will prove invaluable. One important cause often responsible for negative blood cultures is the small quantity of blood collected in the bile tube, and physicians using this method should collect at least 10 to 15 drops of blood in the tube.

As the method not only gives the physician the benefit of the Widal reaction, but also often aids in an earlier diagnosis of typhoid fever, in the detection of carrier cases or in a diagnosis in other than typhoid conditions, it is urged that these combined outfits be used whenever possible.

#### NECATOR AMERICANUS IN SAMOA.

Passed Assistant Surgeon Perceval Sherer Rossiter, class of 1895, U. S. N., in an article entitled "Notes on the Prevalence and Prevalence of *Necator americanus* in Samoa" in the United States *Medical Bulletin*, states that on December 7, 1909, he made a preliminary report upon this subject and reported the finding of the parasite on November 21, 1909.

Since the demonstration of its presence in Tutuila, work toward eradication of the hookworm has been well under way.

The board appointed by the governor, to consider and report upon this subject, advised in substance as follows:

1. The establishment of a board of health whose orders would have the effect of law.
2. The enactment of a law fixing adequate penalties for disregard of orders or regulations of the board of health.

3. That orders be issued requiring the people of the colony to immediately erect and use the best latrines their ability and resources can produce; that these latrines be at once put under proper inspection; and that, as necessity demands and means and material permit, these temporary structures be replaced with others of approved design.

4. That temporarily the hospital steward of the station ship perform the duties of sanitary inspector, and that the Bureau of Medicine and Surgery be requested to allow this station an additional hospital steward to be permanently assigned to this duty.

5. Estimates were made of the amounts of money required for assisting, where necessary, towns in the construction of latrines and paying for other work under the board of health.

6. Recommendations were made of sources from which these funds could be secured.

The governor approved the recommendations of this board and a board of health has been appointed, to consist of the captain of the yard, the senior medical officer, and the secretary of native affairs. The sum of \$1000, appropriated from the customs fund, was made available January 1, 1910, and the board of health was ordered to prepare for the consideration of the governor, health regulations, following the recommendations of the "hookworm board," together with such suggestions as they might see fit to make regarding their enforcement.

There are on the islands of Tutuila and Manua 42 coastal and 11 inland villages, with a total population of 6667.

In order to determine with a fair degree of accuracy what proportion of the native population was infected, 100 persons were selected at random from all parts of Tutuila and Manua as representative of the general population.

The stools of these persons were examined for the ova of intestinal parasites with the following positive results:

<i>Necator americanus</i> .....	51
<i>Trichuris trichiura</i> .....	84
<i>Ascaris lumbricoides</i> .....	10
<i>Oxyuris vermicularis</i> .....	5
<i>Hymenolepis nana</i> .....	4
<i>Myiasis</i> .....	2

If this is a correct estimate of the percentage of the population infected with *necator americanus*,

*cannis*, and he believes it to be fully that high, uncinariasis presents itself to this community as an important sanitary and economic problem urgently requiring attention. Fortunately circumstances are such that the situation will be promptly and vigorously dealt with, and the problem, we hope, ultimately solved.

When local conditions are considered it is not surprising that this parasite, once introduced, should have invaded such a large proportion of the inhabitants; for the requirements for its propagation and dissemination are ideally met.

The soil is everywhere loose and sandy; the rainfall is heavy and the ground always moist; the temperature ranges between 70° and 95° F. throughout the year. The natives are extremely careless of the disposal of feces, and in general defecate just beside, if not in, the roads, or just outside the houses. A negligible percentage wear shoes, and the native costume, the lava lava, a simple strip of cloth about 30 inches wide and 2 yards long, fastened about the waist, permits every part of the body to come in contact with the contaminated soil, for they sit, eat and sleep on the ground or on mats.

When and how the parasite was introduced into Samoa we are, as yet, unable to determine other than that Salter, A. G., in the Australian *Medical Gazette*, states that *Necator americanus*, as well as *Ankylostomum duodenale*, is present in Queensland, and that from the wide distribution and prevalence of the parasite in this island it must have been introduced many years ago.

Many of the infections are found to be very severe, and in one family of eight every member but one, the mother, had a severe degree of infection.

Every case examined to date from one of the inland villages has shown a high degree of infection.

Of the Fita Fita guard, who live under far better sanitary conditions than any other natives, 24.4 per cent. are infected.

A prominent symptom of uncinariasis as it occurs here, and one which he has not seen mentioned heretofore, is a persistent and distressing cough, which resists the usual treatments for bronchitis until after the administration of one or two doses of thymol for removal of the uncinaria,

when the cough promptly disappears. The only apparent explanation of this symptom, which explanation does not, however, fulfill all requirements, is the irritation caused by the young worms in their passage up the bronchi to reach the esophagus.

Doubtless a large percentage of the cases heretofore treated as chronic gastro-enteritis and attributed to the habitual ingestion of great quantities of poorly cooked vegetable matter were cases of uncinariasis. He recalls one patient who died sixteen months ago, her case diagnosed by several competent examiners as miliary tuberculosis, although repeated examinations of sputum had failed to show tubercle bacilli, who, in the light of our present knowledge, he feels sure died of uncinariasis; for every living member of her family has been found infected with uncinaria, and a sister with identical symptoms and a grave infection with *Necator americanus* is rapidly improving under treatment.

The most pronounced cases of perverted appetite so far encountered had a fondness, respectively, for raw rice, starch, soap and live lizards.

The improvement shown by all cases under treatment is marked, and in some very striking.

One adult male at the time of his first treatment had 4,200,000 red corpuscles per cmm. and 12 per cent. hemoglobin. The latter percentage increased in two weeks to 68.

The board of health will have built in every village a sufficient number of public latrines of a type suitable to each locality, and will endeavor by stringent regulations and an active campaign of education to prevent soil pollution. All badly infected areas will be thoroughly cleaned and burned.

An article telling of the presence of the hook-worm in the islands, the symptoms produced in those infected, and the measures necessary to prevent infection was published in the December number of the native newspaper, and already numbers of natives are daily presenting themselves and families for examination, and a popular wave of desire to be treated for intestinal parasites is being encouraged.

Since writing the above five cases from Upolo, German Samoa, have been examined, and all have been found to harbor large numbers of *Necator americanus*.

## ITEMS

Miss Emily Lavinia Ely, class of 1909, University Hospital Training School for Nurses, has been operated on at the University Hospital for appendicitis.

Dr. J. Dawson Reeder, class of 1901, of Baltimore, Md., has removed his offices to the Professional Building, and will limit his practice to rectal diseases.

Dr. Maxey Lee Brogden, class of 1909, of Swansea, S. C., is taking a post-graduate course in the University of Maryland.

Dr. J. Knox Insley, class of 1908, has removed from Tangier Island, Virginia, to the corner of Windsor Mill road and 13th street, Walbrook, Md., where he has opened offices.

Dr. George E. Bennett, class of 1909, has been appointed private assistant in the office of Dr. W. S. Baer.

Amongst our alumni located in South Carolina are:

Claude Clinkscales Gambrell, class of 1868, Abbeville.

James Chisolm Hill, class of 1906, Abbeville.

L. Theophilus Hill, class of 1882, Abbeville.

James Calhoun Harris, class of 1883, Anderson. Marion Augustus Thompson, class of 1880, Anderson.

Joseph A. Anderson, class of 1886, Antreville.

J. B. Black, class of 1872, Bamberg.

Vance W. Brabham, class of 1905, Bamberg.

J. Jennings Cleckley, class of 1904, Bamberg.

Louis Milton Mitchell, class of 1892, Batesburg.

William Cowan Bowen, class of 1891, Belton.

Benjamin F. Carpenter, class of 1899, Belton.

Calvin Grier Todd, class of 1902, Belton.

Robert Othello McCutchen, class of 1907, Bishopville.

Bush McLaughlin, class of 1891, Bishopville.

Ryan Alfred Gyles, class of 1891, Blackville.

Leland B. Salters, class of 1903, Blenheim.

Simon P. Rentz, class of 1891, Branchville.

William D. Hope, class of 1887, Bullock Creek.

William R. Clyburne, class of 1890, Camden.

Samuel Jacob Summers, class of 1892, Cameron.

Lawrence G. Clayton, class of 1878, Central.

William O. Holloway, class of 1899, Chappells. Thomas Duncan, Jr., class of 1905, Charleston. Joseph Maybank, class of 1889, Charleston. Kivey Pearlstone, class of 1906, Charleston. John H. Harden, class of 1888, Cheraw. Harvey E. McConnell, class of 1890, Chester. Ebenezer Widely Pressly, class of 1887, Clover. William M. Lester, class of 1887, Columbia. Robert Love Moore, class of 1896, Columbia. Manney Murdock Rice, class of 1906, Columbia. Charles Frederick Williams, class of 1899, Columbia.

Homer H. Burroughs, class of 1900, Conway. James A. Norton, class of 1903, Conway. William A. Kirby, class of 1886, Cottageville. Cephas C. Hill, class of 1904, Darlington. W. W. Dodson, class of 1888, Donalds. Robert J. Gilliland, class of 1883, Easley. James O. Rosamond, class of 1889, Easley. Wilfred J. Rivers, class of 1885, Easley. William J. Young, class of 1872, Fairfax. Thomas S. Kirkpatrick, class of 1889, Fort Mill. J. T. Darwin, class of 1889, Gaffney. Stephen H. Griffith, class of 1890, Gaffney. S. Baskin Sherard, class of 1905, Gaffney. William Clifton Black, class of 1886, Clifton. Curran Bertram Earle, class of 1896, Greenville.

Davis Furnam, class of 1882, Greenville. Charles W. Gentry, class of 1903, Greenville. R. E. Houston, class of 1904, Greenville. William L. Mauldin, Jr., class of 1901, Greenville.

Bascomb Lanier Chipley, class of 1906, Greenwood.

Rufus Berley Epting, class of 1885, Greenwood.

J. Clarence Harper, class of 1902, Greenwood.

James Baruch Hugley, class of 1883, Greenwood.

The engagement is announced of Mrs. Mary Martin, 103 West Monument street, to Dr. John Dwinelle Fiske, class of 1875, also of Baltimore.

Dr. Arthur Ralph Hunter, a former assistant resident surgeon at the University Hospital, was a recent visitor to the University.

Dr. John Edwin Legge, class of 1899, of Oakland, Md., sailed for Europe October 8, where he

will take a six months' course in medicine and surgery in Vienna, Austria.

Dr. Arthur Mann, class of 1890, of Catonsville, Md., was operated on at the University Hospital for gall-stones.

Dr. Frederick H. Vinup, class of 1909, formerly assistant resident physician at Eudowood Sanitarium and Bayview insane department, has located at 1221 Hollins street and associated himself with the tubercular department of the University Hospital.

Miss Mary Barton Saulsbury, class of 1909, University Hospital Training School for Nurses, is at the University Hospital, suffering with an attack of typhoid fever.

Of the forty-two members of the Faculty of the Maryland Medical College for the session 1910-1911, the following 16 are alumni of the University of Maryland: William Herbert Pearce, '91, Emeritus Professor of Diseases of Children and Clinical Medicine; C. Urban Smith, '89, Emeritus Professor of Theory and Practice of Medicine and Gastro-Enterology; J. William Funek, '88, Professor of Diseases of the Eye; Frederick Caruthers, '92, Professor of Genito-Urinary Surgery; William S. Smith, '83, Professor of Diseases of Women; Alexander D. McConachie, '90, Professor of Diseases of the Ear, Nose and Throat; Albert T. Chambers, '98, Professor of Operative and Clinical Surgery; William S. Love, '90, Professor of Gastro-Enterology and Clinical Medicine; E. Miller Ried, '64, Professor of Medical Jurisprudence; Irvin Ebaugh, '80, Professor of Therapeutics and Clinical Medicine; Henry W. Keinard, '99, Professor of Orthopedic Surgery; Howard Davis Lewis, 1900, Professor of Anatomy and Clinical Surgery; Wilbur Pledge Stubbs, '02, Professor of Materia Medica and Associate in Clinical Medicine; Josiah S. Bowen, '93, Associate in Diseases of the Ear, Nose and Throat; Albert Lafayette Levy, '03, Associate in Physiology, and J. Gilbert Selby, '99, Demonstrator of Anatomy.

The following are visiting surgeons to Franklin Square Hospital: Drs. J. William Funek, class of 1888; Frederick Caruthers, class of 1892; William S. Smith, class of 1883; Alexander D.

McConachie, class of 1890; Albert T. Chambers, class of 1898, and Howard Davis Lewis, class of 1900.

Dr. Robert Lee Randolph, class of 1884, has removed from 816 Park avenue, Baltimore, to 699 Park avenue.

Dr. Herbert Seth Anderton, class of 1910, is located at Clifton avenue and 13th street, Walbrook, Md.

Drs. C. Urban Smith, class of 1889; William Herbert Pearce, class of 1891; William Samuel Love, class of 1890; Irvin Ebaugh, class of 1880, and Wilbur T. Stubbs, class of 1902, are visiting physicians to Franklin Square Hospital.

Dr. John Mortimer Hayes, class of 1901, is private physician to Buffalo Bill (Colonel Cody).

Dr. A. Aldridge Matthews, class of 1900, has been quite ill with typhoid fever for the past two months. He is now on the Pacific Coast recuperating.

Dr. William I. Messick, class of 1895, has purchased the residence situated at the northwest corner of Linden avenue and Wilson street, Baltimore. He intends to convert the lower floor into a suite of offices, which will comprise a waiting-room, a history-taking and record-room, a treatment-room and a laboratory.

Dr. Caleb Noble Athey, class of 1894, is making improvements to his home, Patterson Park avenue and Lombard street. These will cost in the neighborhood of \$3500.

Dr. Thomas L. Richardson, class of 1884, celebrated his fifty-third birthday September 1.

Dr. Oliver P. Penning, class of 1897, was appointed an official representative to the National Conservation Congress, which met in St. Paul, Minnesota.

Dr. Arnold Dwight Tuttle, class of 1906, first lieutenant, Medical Corps, U. S. A., in the *Military Surgeon* of June, 1910, in an article entitled "The Gastrodiscus Hominis in the Philippines,"

reports the first case of infection with this intestinal fluke in the Philippine Islands. The patient was a native Moro who had always lived in the Cotabato Valley, Mindanao. Two adult worms were found. There was no evidence as to the source of infection, though the author suggests that the occasional visits of itinerant Chinese and Indian peddlers might indicate the importation of the parasite.

Dr. William Henry Davis, class of 1902, has removed from 871 Park Place, Brooklyn, to 67 Hanson Place, Brooklyn.

Dr. Joseph Angelo Devlin, class of 1906, is located at 168 West 87th street, New York. He was formerly a resident physician in St. Francis' Hospital.

Dr. Louis B. Henkel, class of 1903, was host at an attractive dinner given at his home at Murray Hill, Annapolis, Md., on September 13, in honor of the members of the State Board of Medical Examiners who attended the semi-annual meeting of the Medical and Chirurgical Faculty of Maryland, held at Annapolis, September 12, 13 and 14. Covers were laid for ten. The appointments were more than attractive. Harvey of Carvel Hall was the caterer, and the following menu was served:

	Soup	
	Tomato Gumbo—(Sherry Wine)	
Olives	Celery	Sweet Pickles
	Fish	
Broiled Spanish Mackerel (Sauterne)		
Chicken a la Caserole		
Broiled Chicken on Toast—		
	(Champagne, Mumm's)	
Potatoes au Gratin	Peas	Lima Beans
	Roman Punch	
	Salad	
	Stuffed Tomato	
	Ice Cream	
Merangues	Fancy Cakes	
	Cheese	
Roquefort	Cream	
Toasted Bents	Crackers	Demi Tasse
	Cigars	Cordials
		Cigarettes

The following University Alumni were present: Drs. C. R. Winterson, class of 1871, of Hanover, Md.; Harry B. Gant, class of 1880, of Millersville, Md.; Randolph Winslow, class of 1873, of

Baltimore, Md.; Charles O'Donovan, class of 1881, of Baltimore, Md.; James J. Murphy, class of 1896, of Annapolis, Md., and Hoagland Cook Davis, class of 1902, of Baltimore, Md.

Dr. J. Bushrod Schwatka, class of 1882, has returned from his wedding trip abroad. Dr. Schwatka was married on July 30, and announcement was made in the August BULLETIN.

Dr. Robert H. Gant, class of 1909, has been commissioned first lieutenant, Medical Reserve Corps, U. S. A.

Prof. Charles W. Mitchell, class of 1881, has returned from a summer in Germany, where he took a special course of study.

Dr. S. R. Donohoe, class of 1902, is located at Norfolk, Va., with offices in the Dickson Building.

Dr. H. E. Jenkins, class of 1905, is on board the U. S. S. Montana, Provincetown, Mass.

Dr. Francis M. Chisolm, class of 1889, is occupying his new residence, 1632 Rhode Island avenue N. W., Washington, D. C. The building has been completely remodeled and converted into an American basement for the accommodation of his offices.

Miss Lucy B. Squires, class of 1909, University Hospital Training School for Nurses, is located at 108 Ramsay street, Bluefield, W. Va.

Dr. Walter W. White, class of 1896, of 1101 Broadway, Baltimore, has been a guest at the Marlborough-Blenheim, Atlantic City, N. J.

Dr. Alex. R. Mackenzie, class of 1910, is located at Charlestown, W. Va.

Dr. G. Timberlake, associate professor of genito-urinary diseases at the University of Maryland, presented a paper on "The Pathology, Symptomatology and Diagnosis of Diseases of the Prostate" before the recent meeting of the West Virginia Medical Society.

Miss Henrietta A. Gourley, class of 1908, University Hospital Training School for Nurses, has

accepted the position of superintendent of nurses of the St. Luke's Sanitarium, Fayetteville, N. C., of which Drs. R. B. Hayes, class of 1906, and T. Marshall West, class of 1908, are the proprietors.

## MARRIAGES

Dr. Percy Roland Fisher, class of 1897, of Denton, Md., and Miss Alma T. Buswell of Winona, Minn., were married at the home of the bride's mother in Winona, Minn., September 29, 1910. Doctor Fisher is the only son of the late Henry C. Fisher, a leading Tuckahoe Neck farmer. He was educated in the public schools of Denton, Western Maryland College, at Westminster, and the medical department of the University of Maryland. He served as interne at the University Hospital, then took up practice in Denton. He is a member of the American Medical Association, Medical and Chirurgical Faculty of Maryland, and the Caroline County Medical Society. Miss Buswell is one of the nine daughters of the late E. M. Buswell, a civil engineer and merchant of Winona. She is a graduate of the Normal School of Winona and the Thomas School of Detroit. She was also formerly a teacher in the Denton High School. After a wedding trip to the North the couple will occupy the new residence recently completed for Dr. Fisher.

Mr. and Mrs. Stanley J. Lewis announce the marriage of their daughter, Miss Floride Lewis, to Dr. Howard Davis Lewis, class of 1900, both of Baltimore. Dr. and Mrs. Lewis will be at home after October 15 at 38 West Twenty-fifth street, Baltimore.

The marriage of Miss Leila Griffith Owings, University Hospital Training School for Nurses, class of 1905, and Dr. Emile Bonniwell Quillen, class of 1905, of Wilmington, N. C., will take place at the Church of the Ascension, Baltimore, on Tuesday, October 18, 1910. Miss Owings is the daughter of Mr. and Mrs. U. G. Owings of West River, Md. Dr. Quillen was a former staff member of the University Hospital. He is now assistant surgeon of the Atlantic Coast Line Railway.

Dr. James Alexander Bond, class of 1901, was married to Miss Bertha George at Glen Marcy,

Md., Saturday, October 1, 1910. The bride is the daughter of the late Mr. James George, and Dr. Bond is the son of Mr. and Mrs. J. A. C. Bond of Westminster, Md. Dr. and Mrs. Bond will live in Parkersburg, W. Va.

Dr. Joseph Howard Hodges, class of 1908, of Harpers Ferry, W. Va., was married to Miss Edna Bell Hendricks of Charlestown, W. Va., October 12, 1910.

## BIRTHS

Dr. Caleb Noble Athey, class of 1894, and Mrs. Athey are receiving congratulations upon the birth of a daughter September 12, 1910. Mrs. Athey was formerly Miss Helen Skipwith Wiemer.

## DEATHS

Mrs. Daisy E. Langley, wife of Dr. Louis E. Langley, class of 1910, died at her home, 1129 Baldwin street, Williamsport, Pa., September 20, 1910. She is survived by her husband and one son, E. Surran Langley, three years old.

Dr. William W. Saunders, class of 1861, died at his home in La Plata, Md., October 6, 1910, after a lingering illness of cancer. Dr. Saunders was 74 years of age, and before his illness compelled his retirement from active work he enjoyed one of the largest practices of Charles county. He received his primary education from Georgetown College, and later matriculated at the University of Maryland, graduating in 1861. He is survived by his wife, formerly Miss Dement, and seven children, as follows: Mrs. Frank Barnes, Miss Anne C. Saunders, and Messrs. W. Eugene, Harry L. J. Allen, Fabian and Edward L. Saunders, all residents of Charles county, Maryland.

Dr. J. S. Sellers, class of 1893, died at his home at Weyer's Cave, Va., September 2, 1910, of abscess of the brain, after an illness of a year. He was a native of Augusta county, Virginia, and was instrumental in founding the little town of Weyer's Cave, Va. He is survived by his widow, who was Miss Rose Root, and three children—Louise, Sadie and Helen Sellers. He was 42 years of age, and was a member of the Reformed Church.

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No. 9

## GENERAL REMARKS ON EPITHELIOMA OF THE TONGUE, WITH A BRIEF REPORT OF A RECENT CASE OF REMOVAL OF THIS ORGAN BY PRO- FESSOR RANDOLPH WINSLOW.

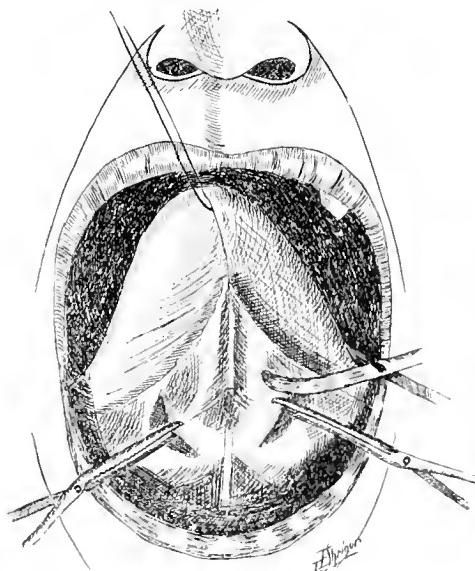
By ERNEST S. BULLUCK, '11,  
*Of Wilmington, N. C., Senior Medical Student,*  
*University of Maryland.*

*Historical.*—In the writings of Hippocrates reference is made to ulcers which the cautery would not cure. Galen believed these ulcers to be due to lack of bile when curable, and to be due to black bile when incurable. Celsus went so far as to urge their extirpation. The first definite knowledge of what must have been cancer of the tongue dates from 1676, when Wiseman described a growth on the tongue. Later these growths were studied more especially by Sir James Paget. In 1819 C. J. M. Langerback removed a triangular area of the tongue, which contained a small growth, and got primary union of the edges. After 14 years G. Mirault ligated the lingual arteries preceding an operation on the tongue. On May 18, 1838, Regenote of Pisa for the first time removed the tongue through the floor of the mouth, and the year following Roux removed the tongue through the mouth after the manner of today. Hilton in 1850 divided the lingual nerve for the relief of pain. About 1877 Whitehead began to popularize the operation of Roux, which now bears the former's name. Based on the work of Billroth and his followers, which began about 1861, Kocher in 1880 described his operation for the removal of the organ, glands and other tissues involved.

*Frequency.*—The increase of cancer is beyond question, when in from ten to thirty years we find the number of deaths from this malady in New York doubled, in Boston tripled, and in San

Francisco the mortality increased sevenfold. In England and Wales the increase is believed to be 150 per cent., while Germany claims the melancholy honor of an increase equaling 266 per cent. These figures cannot be attributed to improved diagnosis, for they go hand in hand with the post-mortem statistics of such old-established hospitals as St. George's and Middlesex.

Of the total number of cancers we find epithelioma constituting 8½ per cent. Of this number the greater percentage occurs in males. In



REMOVAL OF TONGUE BY INTRA-BUCCAL METHOD.—  
CASE OF J. C. J., JULY 19, 1910.

a series of 550 cases reported, 477 occurred in males, while in only 73 cases were females affected.

*Etiology.*—The cause of epithelioma is unknown, and its explanation must await the discovery of the biologic force which controls the co-ordinate growth of the cellular elements of organized structures.

Of the popular theories of cancers, the parasitic seems best adapted to this particular form of

tumor. It has in its favor the increase of cancers, their more frequent occurrence in lowlands bordering on slowly running streams, and their prevalence in certain houses with a constancy that seems far in excess of the law of chance. If the proliferation of normal cells depends upon their invasion by organisms, then it must be conceded that such organisms excrete during their life or yield by disintegration after death, a substance either in the presence of which the epithelioma takes on renewed activity, or by its combination with the tissue elements the normal restraint is satisfied—leaving the cell growth to go on unhampered and misdirected. Yet it is almost certain that the majority of tumors are not parasitic in origin; and because epithelioma possesses so many characteristics in common with the other tumors, a doubt seems to be cast upon its parasitic hypothesis. The association of chronic irritation with such neoplasia suggests that organisms may act as simple irritants, in which case infection might be due to a number of different organisms. The many varieties of organisms found present in these tumors seems to favor this possibility.

Heredity seems to play no part. In the vast majority of cases the epithelioma is preceded by mechanical irritation continuing over a number of years. In the poor it is often due to the heat from a short-stemmed pipe or the jagged processes of carious teeth, while in the rich it may be caused by condiments or illfitting tooth plates. Both classes are attacked with equal frequency. Leucoplakia, syphilis and chronic glossitis may precede the cancer, or the irritation may result from gross mishaps, as from burns by caustic, superheated objects, or by the excessive drinking of alcohol. Only half of the neoplasms occur in smokers, and there is little evidence that it is a predisposing factor of any importance.

Age cannot be overestimated as a predisposing cause. Epithelioma seldom occurs before forty, but after this age there is an increasing frequency with each year.

*Development.*—The epithelioma in about 50 per cent. of cases makes its appearance on the borders of the tongue. Few occur on the dorsum, and still fewer at the tip of the base. On the posterior half of the tongue the growth is extremely uncommon. It most often occurs on either of the two sides of the anterior portion of the tongue.

Most frequently epithelioma is first seen as an ulcer, usually developing on the seat of a blister,

excoriation or fissures, or it may first be evidenced as a small, warty growth. In these instances the condition may be malignant or non-malignant in its beginning. At what time malignancy develops is beyond our knowledge. Clinical manifestations in the first place are seen as an induration and hardening of the base of the ulcer, while in the second case the growth undergoes the same changes followed by early ulceration. In each instance there is a slight inflammatory reaction in the surrounding tissue. The surface of the ulcer may take on a deeper red color with the appearance of a slight discharge, however more frequently the surface becomes fissured with eroded and piled up edges. When the ulcer occurs at the front of the tongue it may spread through its substance to the floor of the mouth, to the mandible and to the neighboring glands. The ulcer occurring on the dorsum sweeps outward to the pillar of the fauces, to the tonsils and to the soft palate. When situated at the base the course of the ulcer is downward, the epiglottis, the larynx and esophagus being successively invaded:

*Varieties.*—Epithelioma may first appear nodular. Such cases are marked by slow growth and delayed metastasis. Again it may appear papillomatous, the warty growth being followed by cancerous infiltration with great constancy. Most commonly, however, the ulcerous type is encountered, and both of the above forms become so soon after their appearance. The scirrhus form is sometimes seen, in which case the tongue is hard and elastic, is irregularly furrowed or smooth and glazed. Rarely is epithelioma double, and in no known instance have three such growths occurred synchronously. When the growth follows syphilis or chronic glossitis it may be diffuse. The hypertrophic type with protruding tongue is seldom seen.

*Dissemination.*—Metastasis is early and certain, always within first few months. Often it has occurred when the primary growth is first noted. In the few instances where enlargement of the glands has preceded the appearance of the gross lesion on the tongue, there is the possibility that the increased glandular tissue might be due to other diseases, perhaps to the irritation leading to the growth. Metastasis to remote parts of the body is uncommon. This is not because the conditions suitable for the growth do not exist elsewhere, nor is it due to the fact that the duration of the disease is too short to allow the metastatic

growth to become recognizable, but to the efficiency of the lymphatic system draining the mouth. Malignancy once having begun, the contraction of the muscles of the tongue causes dislodgement of tumor cells, which are carried through the lymph to the glands draining the area involved by the tumor. Here the cells lodge, adapt themselves to the new surroundings and begin to multiply. Cases of more general metastasis sometimes occur, and in these instances the liver and lungs are most affected, while the bronchi, cortex of the kidney, suprarenal capsules and the walls of the heart rarely become involved. When the tip of the tongue is the seat of the tumor, the submental glands are first affected. Involvement of the middle of the tongue and floor of the mouth endangers the submental, submaxillary and parotid lymphatic glands, and affection of the base may involve the deep cervical glands. The lymph vessels cross the median line of the tongue, and freely anastomose so that in a given case one cannot foretell with any degree of certainty just what glands may foster the wandering cells. The glands when first affected become hard, then enlarged and later immovable. They may undergo degenerative changes, break down and discharge through the skin. The growth may then subside, the glands shrinking, but never losing their malignant nature.

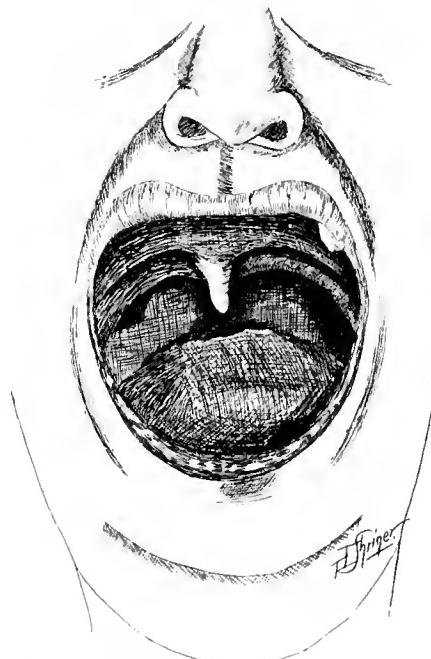
*Pathology.*—The growth arises from the squamous cells of the mucous membrane, and never from the glandular epithelium. It begins with the down growth of columns of these cells into the underlying connective tissue; they diverge, branch and anastomose so that the invading columns become reticulated. The down growths are devoid of limiting membrane, but are clearly defined. The cells rest on the basement membrane common to epithelial structures, and are orderly in arrangement and vertical in position. The epithelium is smaller than normal. The protoplasm of the cell is granular and contains within itself often one or two nuclei of large size. The central and oldest cells of the columns may undergo keratization. The concentric arrangement of the surrounding cells in this case gives rise to the epithelial pearls so constant in this form of malignancy.

*Symptoms.*—Pain always exists to some degree, the intensity increasing with the progress of the disease. It may be sharp, gnawing or aching in character, at times radiating to the external audi-

tory meatus, the submaxillary and temporal regions of the side involved. It is of constant duration, but aggravated by the trauma and movement incident to eating and talking.

Salivation, which is a constant source of discomfort in this malady, is due to reflex irritation and begins early. Late in the disease it may be very profuse. The breath is very foul, swallowing and articulation are difficult, and are rendered more so when involvement of the floor of the mouth immobilizes the tongue.

*Diagnosis.*—Any growth on the tongue of an individual, who has passed the age of thirty,



STUMP AFTER REMOVAL OF THE GREATER PART  
OF THE TONGUE OF J. C. J., JULY 19, 1910.

should be studied with regard to its possible malignancy. If the characteristics described above are present in part or whole, the diagnosis usually follows the exclusion of those affections which have lesions similar in appearance. Secondary syphilis gives little chance for error. The infrequency of chancre on the tongue, its presence at the tip and the finding of the spirochete pallida differentiate this from epithelioma. Unbroken gumma of the tertiary stage may be mistaken for the nodular type of the growth, for both occur on the dorsum of the tongue, are at first ill-defined, of slow growth and affect most commonly those who have passed the third decade of life. Specific history and scars on the tongue, evidences of syphilis elsewhere in the body, frequency of

multiple gummata and the Wasserman reaction will, however, differentiate these. The gumma occurs most frequently on the dorsum of the tongue. If ulcerated, its edges are ragged and undermined; the lymphatics are seldom involved. In epithelioma the predilection of the edges of the tongue for its seat, the unilateral growth with edges hard and nodular, and the early involvement of the lymphatics, show its malignant tendency.

The therapeutic test for syphilis requires precious time, and its routine use may allow the invasion of the glands which might have escaped had the growth been promptly removed.

Warty growths on the tongue are very prone to cancerous infiltration, and it might be well to consider them malignant from the beginning. Simple ulcers have a greater inflammatory zone. They occur at all ages and show a decided tendency to heal after the removal of their cause, but such ulcers may become cancerous. Induration of the base is the first evidence of this change.

Tuberculous ulcers may give rise to grave doubts, as they commonly follow injury. Often they occur at the border of the tongue, and are seen mostly in men. The organism may escape the most diligent search. However, such ulcers are seldom primary, and the discovery of the disease in other organs should lead to further investigation. In typical instances the edges of the ulcers are not indurated; its surface is pale, pink and often it contains yellow patches of caseous material. If doubt still exists, positive evidence follows the removal of a small fragment from the border for microscopic examination. This is best done under local anesthesia. Care should be taken to obtain a specimen well within the border of the lesion, lest it show only the inflammatory changes of the surrounding area.

*Prognosis.*—The prognosis is nearly always bad. Metastasis is early, and the prophylactic removal of glands thought to be normal often shows cancerous invasion. Gastro-intestinal disorders are frequent. There may be violent hemorrhage from the erosion of a large vessel. Recurrent bleeding may predispose to intercurrent diseases, broncho-pneumonia holding first place in frequency. Instances of only five months' duration of the disease are recorded. Cases without operation succumb usually in from twelve months to a year and a half, and but seldom does the victim survive two years.

*Treatment.*—The treatment is purely surgical. The local application of caustics merely increases the rapidity of the growth. The patient's only hope lies in complete removal of the neoplasm and the affected glands. When the growth involves the tip of the tongue an incision is made on each side, converging to a point well beyond the affected area in the healthy tissue. After the removal of this triangular area the lips of the incision are sutured together. Opportunities for such an operation are exceptional. In most instances when the patient comes to the surgeon the condition demands the removal of the tongue. Whitehead's method is as follows: The tongue is drawn well forward of the fauces, and the operator boldly cuts through the frenum linguæ and mucous membrane, and frees the tongue horizontally to a point beyond the focus of the disease, then divides it transversely across its base. The field of operation is well sponged, and as the lingual arteries are reached the vessels with the surrounding tissue are clamped and the musculature completely divided. After the removal of the tongue the vessels are reclamped and securely ligated. In the operation the instrument of choice is the scissors, the curved variety being best suited to work in the mouth cavity. The use of styptic varnishes, the application of dusting powders or the frequent washing with antiseptic solutions are of about equal merit in favoring the rapid healing of the stump.

A preliminary operation for the removal of the cervical and such other glands as may be involved during which the lingual vessels are ligated lessens the metastatic danger, allows a nearly bloodless operation, and removes the danger of secondary hemorrhage. More extensive operations come into play when the disease affects the base or after it has spread into the oral cavity or invaded the tissues of the neck. In these cases the procedure depends on the structures involved. Complete removal of the growth is often impossible, and partial extirpation merely imposes an useless operation on the poor sufferer. In hopeless cases ligation of the external carotids and their branches impedes the progress of the growth. Resection of the lingual nerve will for a time arrest the pain, but this does not affect the glossopharyngeal nerve or the pain in the ear, and consequently the patient is subjected to an operation

from which little benefit results. The appropriate use of analgesics will be found far better.

REPORT OF CASE, JULY 19, 1910. OPERATOR, PROFESSOR WINSLOW; ASSISTANT, DR. COLEMAN; ANESTHETIZER, DR. WILLSE.

J. C. J., married, age 72, home in Baltimore, white American.

*Previous History.*—He has had no illness to his knowledge during his life.

*Family History.*—No evidence of malignancy, syphilis or nervous diseases.

*Complaint.*—Lump on tongue.

*Present History.*—Lump was noticed about seven months ago, situated at right border of the tongue, two inches from tip. In appearance it was nodular and firm, with ill-defined borders and no surrounding inflammatory area. Pain was moderate, confined to the lesion and increased by activity of the tongue. Salivation was present to a slight extent. His teeth were lost nearly twenty years ago except the right upper canine, remote from the lesion. Has neither chewed nor smoked tobacco for the last twenty-five years. As a young man he seldom drank. During the late years has been a total abstainer. The tongue was never the seat of injury or disease within his knowledge. Glandular enlargement in right anterior triangle was observed a few weeks after the lump was first noticed on the tongue. These enlarged glands were about the size of a hickory nut, hard and not adherent. No glandular metastasis was observed on the left side.

*Operation.*—This was done in two stages. First, the lymphatic and salivary glands were removed from the superior carotid triangle on both sides, and the lingual arteries ligated at this time. Second, after an interval of about ten days the tongue was removed by the Whitehead intrabuccal method. A strong silk suture was passed through the tip of the tongue, by means of which it was pulled upwards and outwards: the frenum and mucous membrane connecting the tongue with the floor of the mouth was divided and the tongue easily severed from its attachments until well beyond the cancerous area, when it was divided obliquely near its base. Bleeding vessels were easily clamped and ligated, and the raw surfaces were covered as much as possible with mucous membrane.

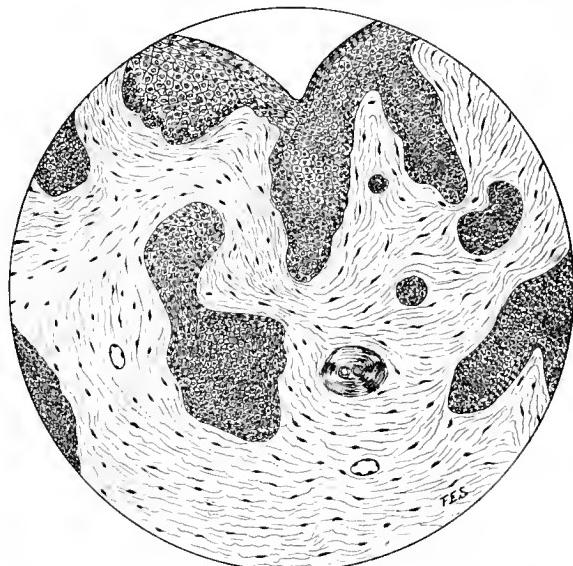
A long, double ligature was passed through the stump of the organ in order to draw it for-

ward in case of impeded respiration from closure of the glottis.

The after-treatment consisted in the application of iodoform gauze and the frequent use of anti-septic mouth washes.

The patient made an unimpeded recovery, and when he left he could eat all kinds of food and could speak so as to be understood, but, of course, with some impediment.

About the time this patient left the hospital another man, whose tongue Professor Winslow



MICROSCOPIC SECTION FROM THE GROWTH REMOVED FROM TONGUE OF J. C. J., JULY 19, 1910.

had removed in 1905, returned to have a recurrence removed from the left superior carotid triangle. This man was 78 years of age, and has had four years of comfortable existence since the removal of the tongue. His recurrent growth was removed and he has returned to his home.

NOTE.—I am indebted to Mr. F. Earle Shriner, class of 1913, for the illustrations.

Dr. Albert H. Carroll, class of 1907, of Baltimore, chief of clinic to the chair of diseases of the stomach, University of Maryland, has an article entitled "Adiposis Dolorosa (Dercum's Disease) in Mother and Daughter" in the October 15, 1910, issue of the *Journal of the American Medical Association*.

Dr. Branch Craig, class of 1909, is doing post-graduate work in Baltimore. After January, 1911, he expects to locate at his home in North Carolina.

## GASTRO-ENTEROSTOMY.

By ELIJAH E. NICHOLS, '11,  
Senior Medical Student.

Gastro-enterostomy is the establishment of a permanent fistula between the stomach and small intestines in order to side-track the pylorus. This operation is performed for cancer of the pylorus, for non-cancerous stenosis of the pylorus, in some cases of ulcer of the stomach and for tetany. This operation was first performed by Wölfler, at the suggestion of Nicoladoni, on September 28, 1881. For some years later so little confidence was placed in this and other operations on the stomach that cases were, as a rule, treated medically until almost moribund before surgical treatment was considered advisable, with the result that the mortality was appalling. From 1881 to 1885 the mortality following this operation was 65.7 per cent. At present, however, the results are more gratifying, the mortality being only about 2.6 per cent. With these results it brings the procedure well within the realms of safety, and, seeing it has to be undertaken in many cases that would be otherwise inevitably fatal, it may be looked upon as an operation the benefits of which not even the most conservative practitioner can afford to ignore. These changes have been brought about not only by patients being operated on at an earlier stage and under more favorable conditions, but also by greater care in technique, by greater expedition in operating, by more careful asepsis, by the avoidance of or the greater care in the use of irritating antiseptics, by the prevention or better treatment of shock, by care in post-operative treatment and by careful preparation of the patient.

*Preparation of the Patient.*—If the stomach is greatly dilated and the contents are foul, then lavage with simple boiled water night and morning is adopted for two days before operation. The last light meal is given the night before—about 12 hours—and a nutrient enema is given about one hour before operation.

There are two distinct methods of gastro-enterostomy—one, Wölfler's, in which the jejunum is fixed to the anterior wall of the stomach, and the other, von Hacker's, in which the anastomosis is affected between the jejunum and the posterior wall of the stomach. The posterior op-

eration, modified slightly by Mayo, Monyhan, Littlewood and Keene, is as follows: The abdomen is opened by an incision about four inches long, one inch to the right of the median line above the umbilicus. The stomach is thus exposed and sterilized gauze is laid on the abdomen surrounding the wound. The great omentum and the transverse colon are then lifted up and brought out of the wound, thus exposing the under-surface of the transverse mesocolon and the attached part of the jejunum on the left side of the second lumbar vertebra. The bowel is caught up in a clamp, just beyond the duodeno-jejunal flexure, at which place the anastomosis is made, thus avoiding any loop. A vertical slit is then made in the transverse mesocolon between the blood vessels, which can be readily seen. By pressing with the left hand above the colon the posterior wall of the stomach is made to project through the opening in the mesocolon, the lower border of the stomach being readily recognized by the blood vessels which are coursing along it. The most dependent part of the stomach close to the lower border is then brought through the slit and grasped and held by a clamp, with small rubber tubing pulled over the blades to prevent injuring the tissues. The great omentum and transverse colon are then returned into the abdomen above the parts to be anastomosed and covered with a sterilized gauze pad.

The two clamped portions of the bowel and stomach are now placed side by side with a strip of gauze behind them. A continuous suture of celluloid thread in a curved needle is employed to unite the serous surfaces for a distance of from two to two and a half inches, the needle there being laid aside still threaded. The two viscera are incised one-quarter of an inch in front of this serous suture and the edges are united by a chromic catgut suture, which takes up all the coats and brings into apposition the mucous membrane of the intestine and stomach. This suture is continued around the circle until it reaches the point where it began, when the suture is at once tied and cut short. Now the serous suture previously laid aside is taken up and continued round the front half of the circle in front of the newly made opening until the point is reached where it began, when the two ends are knotted and cut short. The edges of the aperture are thus united firmly by a serous and a marginal suture. The clamps are now removed and the piece of gauze

behind the anastomosed viscera is then drawn out and the omentum and stomach are brought down to their normal position. If the slit in the mesocolon is large and not completely filled by the anastomosis, two or three interrupted sutures are used to unite the margins of the mesocolic opening to the stomach or jejunum. The abdomen is closed in the usual manner. Monyhan in this operation makes an oblique opening in the stomach wall, and W. J. Mayo displaces the large vessels coursing along the greater curvature of the stomach.

The use of the Murphy button is advocated by some, and consists of inserting one before the anterior half of the circle is closed. This acts by causing pressure necrosis of the opposed surfaces. It can be done a little quicker, but the two fatal objections to its use are (a) the small size of the opening, which tends to contract, and (b) the danger of the button falling back into and being retained in the stomach, a danger which is proved to have frequently occurred in practice, necessitating in many cases a further operation. In one instance it has fallen back into the stomach and has been retained for 86 days. Mayo claims that 20 per cent. of all buttons are imperfect and dangerous.

*Anterior Gastro-enterostomy.*—This is performed like the posterior, except that in this case the anastomosis of the stomach with the jejunum is made at the lower border of the anterior surface, and instead of the attachment being made close to the commencement of the jejunum, as it is in posterior gastro-enterostomy, it has to be made at least 12 to 15 inches from the jejunal attachment, since the jejunal loop has to pass over the transverse colon in order to reach the point of attachment to the stomach, otherwise it differs in no respect from the post-operation. The disadvantage is the long loop of jejunum, which is apt to give rise to the so-called vicious circle or regurgitant vomiting. Therefore, the posterior variety is always to be preferred except (1) when the mesocolon is very short, giving no room through which to make the anastomosis; (2) when extensive and firm adhesions of the posterior wall of the stomach prevent a portion being drawn through a slit in the mesocolon; (3) when cancer invades the posterior wall so extensively as to leave no part of it safely available for operation.

*After-Treatment of Gastro-enterostomy.*—As

soon as the patient is out of ether, place him in the Fowler position. Mayo begins in from 16 to 20 hours to administer by mouth one ounce of hot water every hour, to be increased if well tolerated, and in 36 hours liquid food is given, and if tolerated it is continued.

#### INFANT-FEEDING.

By Nathan Winslow, M.D.

As woman's milk is the best infant food, it behoves us, as physicians, to familiarize ourselves with its character, exact composition and variations; moreover, all modification is based upon the human article, it being our constant endeavor to approximate as near as possible mother's milk. It is not a filtrate, but a true secretion, of a bluish color, slightly alkaline or neutral in reaction, with a specific gravity of 1029-1033, a sweetish taste, and under normal conditions is perfectly sterile. As it contains all the elements, fats, carbohydrates, proteids, mineral salts and water needed in the metabolism of the human economy, it is a composite food. During the first few days of the puerperium the amount may be very scanty, but usually on the third or fourth day the flow is well established.

The proteids, lact-albumen and casein present vary from 1 to 2 per cent. This constituent is pre-eminently a tissue repairer; indeed, it is essential to life, and finds its greatest utility in replacing the nitrogenous waste of the body. Even if fats and carbohydrates are omitted from the diet, proteids are capable for a time to prevent a loss of weight, but more food will have to be consumed, as 22 parts of proteids can only perform the work of 10 parts of fat. Hence by the proper and judicious addition of carbohydrates and fats one-third of the proteid will be sufficient to replace the nitrogenous waste. In the infant's dietary these proteids are furnished by the casein and lact-albumen of human and cow's milk, the white of eggs, muscle fibers and gluten of wheat. The easiest to digest are those furnished by human milk. Casein is held in suspension by the sulphate of lime present, but the lact-albumen, which resembles serum albumen, is in solution.

The chief function of fat, which constitutes 3 to 4 per cent. of the milk, is the production of animal heat. Although an animal can exist on

a strictly proteid diet, it requires 22 parts of protein to accomplish the work of 10 parts of fat; hence the conserving of that part of the nitrogenous food which would be spent in the production of heat is of no little importance to the human mechanism, and the force of the proteids are entirely exerted in the nutrition of the body. More fat than is absorbed is supplied to the nursing infant, so as to give a proper consistency to the stools; therefore, in constipation, increase the fats. In artificial feeding do not make the mistake and order too little fat; infants fed on cow's milk should digest 3 per cent. fat in the first four months and 4 per cent. the latter part of the year. If fats are too low for any length of time, rickets is apt to occur. Fat is stored up in the body as adipose tissue, to be called into service when necessary.

Carbohydrates in the proportion of 6 to 7 per cent., which exist in the form of lactose, as the intestinal canal is not in the condition to act upon starch, are the least disturbed of all the constituents of milk, and are in complete solution. As the ingestion of sugar increases fat, its principal function is the maintenance of heat. Its extreme palatability is of no mean value in enticing the child to proper nursing habits.

The mineral salts consist mostly of carbonate and phosphate of magnesium, iron compounds, calcium phosphate and sodium chloride in the proportion of 0.2 per cent., which is about one-quarter the amount present in cow's milk. Owing to the rapid growth of the bones, they are of great importance.

The food must consist of 80 to 90 per cent. water in order to dissolve and hold in solution sugar and some of the proteids and emulsified fats. This element keeps the food freely subdivided, and allows the secretions of the feeble digestive organs to act upon the intestinal contents more easily. The child needs plenty of water for the rapid elimination from the body of tissue waste. When the child nurses we have to give very little water, but when it eats solid food we should give it plenty of water.

During pregnancy there is a general upbuilding of the mammary gland, the connective tissue is increased, and the glandular elements are proliferated. Very early a substance (not milk, but called colostrum) is produced. After lactation is completed, 10 or 14 months after pregnancy, as the mammae undergo a retrogressive metamor-

phosis and return to the quiescent state, colostrum reappears. Mammary activity occupies a period of 18 months, first six of preparation; during the succeeding 11 months the breast is in its best functional condition, and in the last month it is retrograding. Colostrum, the substance secreted before and two or three days after birth, differs greatly from milk. It is a yellowish alkaline fluid, with a specific gravity of 1.042; it is rich in mineral matter and proteids, but correspondingly poor in fats and sugars. It is a natural laxative, and rids the alimentary canal of meconium and prepares the mucous membrane for absorption. Heat converts it into a solid mass. Colostrum differs from milk in being full of colostrum corpuscles, to which it owes its yellow color. They are five or six times the size of fat globules, and are probably epithelial cells which have undergone fatty degeneration, under a microscope being highly refractive and irregular in shape. These corpuscles should entirely disappear from the milk by the tenth or twelfth day, to reappear during the last days of lactation. Colostrum is not as sweet as milk; when it reappears late in lactation it is generally, but not always, an indication that the child should be taken from the breast, or digestive disturbances will ensue.

*Conditions Affecting the Composition of Woman's Milk.*—Milk equilibrium, the nicety of adjustment which exists between the needs of the child on the one hand, and the quantity as well as quality on the other hand, is not fully established until some days after parturition. As the quantity depends upon the demands of the child, the absence of stimulus after birth retards the secretion; or, in other words, the more vigorous the child, the more prompt the milk flow. Therefore, the best agent in producing a large supply of milk is the constant application of a hungry child to the breast. In general, American women have a very poor flow of milk. Artificial feeding, as it removes the stimulus, is fatal to the establishment of the proper functional activity of the mammary gland; moreover, the percentage composition or quality of the milk varies according to the intervals of nursing—the less the interval, the richer the milk. So when the milk equilibrium has once been formed, you have to be careful about the time of feeding, or you will change the ingredients. Milk equilibrium, when fully established, responds very promptly to the food of the woman. A vegetable diet diminishes; a nitrogenous increases both the

fat and the proteids. A starvation diet diminishes the fat, while the proteids may be lessened or increased; if the latter, they are changed in character. All fluids tend to increase the quantity. If there is too much fat in mother's milk, reduce the proteids she consumes, while in cases of insufficiency a generous supply of meat should be given to the mother. When we are confronted with a case supplying too much protein, we should see that the woman takes plenty of exercise, whereas in case of deficiency rest is the treatment. The nursing woman should consume a plenteous supply of simple food, and should drink large amounts of such liquids as milk, gruel, etc. The diet should not consist of absolutely nitrogenous or vegetable matter, but should be varied. Avoid salads and highly-seasoned foods, because they interfere with the digestion of the nurse. Permit all of the common vegetables, and fruit in season. Prohibit strong tea or coffee; either may be taken weak once a day, but cocoa is better than either. The nurse should drink milk or gruel at bedtime. In an overfed woman there is an undue quantity of milk secreted. Even exercise affects the equilibrium; if insufficient, the mammary gland acts as an excretory organ. During an acute illness of severe type, if prolonged, the quantity is apt to be diminished, the fat low and the protein high. During normal menstruation no ill effects upon the child are noticed. During pregnancy the milk is lessened in amount, and very poor in fats. The milk of very young women and those over 35 years of age is likely to contain less fat than that of a female between 21 and 35. Nervous impressions have a decided and immediate effect on the milk supply; fatigue, great excitement, shock, fright, grief and passion disturbs the secretion, and an infant who nurses under such circumstances may develop acute indigestion.

The following drugs act sometimes through the mother's milk upon her infant: Belladonna, opium, potassium iodide, mercury and the bromides.

Just as soon after delivery as the mother has obtained a little rest, the child should be put to the breast, for it gets both acquainted with the act, the uterus is reflexly affected and the nipple is drawn out; besides, colostrum is supplied to the intestines. During the first 24 hours the child

should be given four nursings, and on the second day should be fed four times. If the infant is very vigorous and cries, satisfy its cravings with sugar-water, but above all things avoid gin and other alcoholic beverages. After the third day, as the milk secretion has been fully established, the child should be put to the breast during the day every two hours, but at night there should be only two feedings. After the first month, the gastric capacity having considerably increased, you can lengthen the intervals to two and one-half hours, and only give eight meals a day. During the fourth month the child should be nursed seven times daily. After the fifth month the capacity of the stomach is more than three times that at birth, and the baby should be fed six times a day, and not at all during the night.

The gastric capacity at birth is reckoned as 1 per cent. of the body weight, so if the child weighs 100 ounces, its gastric capacity is one ounce, and during the early months one-thirtieth of an ounce is added for each day of life.

With the growing digestive capacity the quantity of the milk will be increased, but the quality will not be much affected. A diminution of the quantity is the most frequent disturbance, for with very young mothers the flow at first is normal, but gradually the secretion becomes poor in quantity. The breast should be firm, and should, upon palpation, be lumpy. The nipple should be erectile, and by drawing it between the thumb and first finger milk should be easily exuded. Torturous veins indicate a very full or an evacuated breast. After nursing, the mammary gland should be flabby. If you have means of weighing the infant, you can determine how much nourishment it has ingested. Mere mechanical massage of the breast will alter the quality of milk.

In cases of deficient supply of milk a progressive gain in weight of the child is lacking, sleep is interrupted, the patient waking with a cry after a few minutes of sleep, and is continually putting its fingers to its mouth. The temperature, if taken, will be found to be elevated.

When fat is insufficient, the extremities are cold, the temperature may even be subnormal, the body weight is at a standstill and the patient is constipated. If totally absent, there is a lateness in crawling, walking, eruption of teeth and closing

of fontanelles. Rickets is the result of a constant lack of fat.

An excessive fat consumption is indicated by the presence of an excessive degree of distress an hour to an hour and a half after eating, a vomiting of an acid, malodorous fatty substance, diarrhea and fatty stools.

When proteid is deficient, the child is always hungry, and is continually uttering long cries. It leaves the breast loathfully. The muscles are soft, and there is a loss of weight, the circulation is feeble, and the child is anemic. If excessive, there is intestinal colic, the abdominal walls are tense, hard and distended. Diarrhea, alternating with constipation, is an extremely important diagnostic sign. There may be vomiting, which is often attended with prostration. If the proteids are supplied in great excess, intestinal indigestion may be the result, in which case we may look for nervous phenomena.

In naturally-fed children disturbances from sugar are extremely rare and uncommon. If the diet is too rich in carbohydrates, the body weight, but not the strength, is increased, the resisting powers are lessened and the child is prone to rickets. Stools are green in color, acid in reaction; accordingly, an ulcerative dermatitis of the skin around the buttocks is produced. Flatulence is present, and diarrhea supervenes.

*Woman's Milk Too Small in Quantity.*—You should encourage the woman, that she will succeed in nursing. Plenty of water and large quantities of liquid food, with the exception of coffee, which seems to dry the milk up, should be prescribed. Tea, if desired, may be taken in moderation.

*Woman's Milk Too Abundant.*—Regulate the diet, limit the consumption of liquids. Compel the mother to take plenty of exercise. Administer mild saline purges if the patient does not respond to the above-mentioned measures.

*Contraindications to Nursing.*—According to Colle's law, mothers are almost never infected by suckling their own syphilitic offspring; on the other hand, tuberculosis, insanity or chorea in the mother is an absolute contraindication to nursing.

*Weaning.*—Weaning signifies the deprivation of the child of the breast. In case of normal development of the child there will be certain indications for the consummation of this act. About the ninth or tenth month we should commence to feed the child artificially once or twice daily. If

this policy is followed, the secretion of the mammary gland, owing to the reduction of its stimulus, becomes gradually nil. In all cases weaning should be done gradually.

[TO BE CONTINUED.]

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Dr. Frederick Straughn, class of 1870, now located at 9 Astor place, Jersey City, N. J., is a native of Maryland. Dr. Straughn was born at Greensboro, Caroline county, February 8, 1845, the son of Henry and Martha (Smith) Straughn, and comes of Scotch, English and French ancestors.

His earlier literary education was gained in the public schools of Caroline county, the West River Institute of Anne Arundel county, Md., and Fort Edward Preparatory School at Fort Edward, N. Y. He graduated in medicine at the University of Maryland in 1870. Dr. Straughn has been practicing continuously since graduation, beginning at Denton Md., where he remained for five years, then moved to Jersey City, remaining ten years, after which he spent four years in New York city, and then returned to Jersey City, where he has since remained. From 1885 to 1890 he was City Physician of Jersey City. Dr. Straughn is a member of the Hudson County Medical Society. He is a Mason and a member of the Protestant Episcopal Church. In 1877 Dr. Straughn married Miss Corinne Saulsbury of Maryland, and has four children—Henry Allen, Frederick Stiles, Norinne Allen and Octavia Saulsbury Straughn. Dr. Straughn has an extensive practice, and we beg to wish him well in all his endeavors.

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Dr. Charles W. McElfresh, class of 1889, clinical professor of medicine at the University of Maryland, is holding a doctors' conference every Thursday at 1 P. M. in the University Hospital. He is at present engaged in discussing the various aspects of diet. All physicians are welcome.

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Dr. J. Fred Adams, class of 1894, 1314 North Charles street, Baltimore, his wife and son, while riding in their carriage near their country home, Catonsville, Md., were painfully, but not seriously, injured by being shot by a rabbit hunter. Dr. Adams was wounded in the lip. The shot was extracted at the University Hospital.

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Dr. Frederick Dennison Carpenter, class of 1907, is located at Ephraim, Utah. •

# THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, MD., NOVEMBER 15, 1910.

## THE HONOR SYSTEM.

At the last meeting of the adjunct faculty held Tuesday evening, October 18, 1910, some very important matters relevant to the welfare of the University were discussed. Amongst these questions was that of the introduction of the honor system into the medical department of the University of Maryland. With this idea in view a committee was appointed to confer with the major faculty to ascertain its practicability. Many abortive endeavors have been made to introduce the honor system into our institution, but always with failure. This may have been the result of the half-hearted way in which the matter was approached. To say the least, it is a sad commentary on our students that they, or at least the majority of them, desire to be watched during examinations. If the faculty would broach this question in the proper way, the writer, for one, does not believe the students would turn it down. Our men are equal in intelligence, integrity and honor to the student body in any American institution.

To our mind the cause of the lack of interest in the honor system is due to the fact that we have no University Spirit. The students not living in dormitories do not come into intimate contact with each other and, as a result, have not developed an *esprit de corps*, no enthusiasm, no genuine love for the University. We have no ideals to which they should look. Set up high ideals, create in the students a pride in our accomplishments and the honor system will be a natural result.

## ABSTRACTS

### THE TREATMENT OF RECTAL FISTULA.

Dr. J. Rawson Pennington, class of 1887, of Chicago, Ills., in a paper of the above title, read before the American Proctologic Society, Twelfth Annual Meeting, June 6-7, 1910, St. Louis, Mo., referred to three methods of treatment. (*Southern Clinic*, October, 1910) as follows—simple incision, the injection of bismuth paste, the incision or excision with immediate suture, (Proctorrhaphy).

Of the *Simple Incision*, he said: "Those of us who are operating quite frequently for this malady know its disadvantage, drawbacks, and frequent failures to cure, and that this operation has done more than any other, unless it be that of the ligature or clamp and cautery operation for hemorrhoids, to bring disrepute upon rectal surgery. That the laity dread a rectal operation more than any other surgical procedure because of the fear of pain, the fear of non-recovery and the fear of loss of control over the bowels. Yet, we know that the above operations in the hands of experts give good results." Concerning the injection of bismuth paste, he said: "To treat a rectal fistula, the paste is liquefied by heating in a water-bath and injected into one of the openings with a metal or glass syringe. The other opening or openings are kept closed by an assistant while the injection is being made. Enough force is used until one feels reasonably sure that all tracts and diverticuli have been filled. The paste may be forced into some line of cleavage if too much tension is used and carried along in this line to some distant organ or healthy tissue and deposited there with deleterious results."

Of the excision or incision with immediate suture (Proctorrhaphy), he said: "This method is the most rational of all surgical procedures, that he dissects and removes the entire tract when a probe or director can be passed through the fistulous channel and into the rectum. That he then searches out and removes any diverticuli or tracts connected with the main tract. If this can not be, or should not be done, he then incises the fistula and dissects out all granulation tissue. If needs be the wound is disinfected with carbolic acid and alcohol.

"Suturing the wound may be done by lengthening the line of incision from its termination in the rectum to the anus. The ends of the severed

sphincters as well as the deeper portions of the incision are next brought together with interrupted catgut sutures. The skin and fascia are sutured with interrupted silk worm-gut. He dresses the wound with iodoform or plain gauze and applies a T bandage. He maintains that Proctorrhaphy, or the paste, or a combination of the two, offers the nearest approach we have to the ideal method of treating extensive rectal fistula."

#### CHILDHOOD AND YOUTH AND THEIR RELATION TO THE PUBLIC HEALTH PROBLEM.

Dr. Thomas Allen Mann, class of 1903, in an address upon the above topic before the North Carolina Medical Society at Wrightsville, N. C., June 23, 1910 (*Bulletin of the North Carolina Board of Health*, September, 1910), has the following to say:

"It is said that a constant drop will wear a stone. If this is so, our present plan of teaching the public by lectures and literature in matters of sanitation will avail something, perhaps much, but not as much as modern scientific knowledge has prepared us to avail ourselves. To the great credit of the medical profession, the knowledge of disease prevention and the practical remedies to be applied are far ahead of the public desire or the public willingness to find out and apply these remedies. We who are well aware of the evil result of disobedience to certain natural laws are often astounded at the persistent carelessness and apathetic indifference of some of our most intelligent citizens, after they have been warned time after time of their dangerous habits. As a flagrant example, let me cite the case of a physician's family in which the son, the son's wife and one child recently died of typhoid fever. A second child recovered after a long and costly illness in a hospital. These persons contracted typhoid fever from contaminated spring water after they had been repeatedly warned by their brother, who is an honored member of our State Society. If this man and his wife themselves used and permitted their children to use this dangerously polluted water, when personally warned repeatedly of its danger by one whose knowledge could not be questioned, we are forced to admit that ordinary warning in the shape of literature, lectures, etc., to the general public fails to obtain results commensurate with modern scientific knowledge.

"Such diseases as typhoid fever ought not only to be in a great measure prevented, but they should be completely eradicated. In the light of our present knowledge, when a person dies of typhoid fever it can truthfully be said to be either suicide or homicide. But while we talk and write, these suicides and homicides go on without protest. What is the remedy? There is no doubt in my mind that it depends in a great measure on a more careful training of our children in our primary schools and of students in our colleges and universities. It is the purpose of this paper to urge the members of this society to use their influence before school boards and boards of trustees, superintendents and college presidents to impress the great need of such training.

"There is no way to measure the exact relations between social and commercial prosperity and public health. The history of the ancient empires of Greece and Rome is interesting to medical scientists in connection with this question, and seems to show that the relationship is a vital one, for it is said that the downfall of these great nations was due primarily to malarial fever. In more recent times we have the history of the failure of France to dig the Panama Canal on account of the lack of sanitation—the failure to recognize the importance of preventive medicine. Following this failure, we have the example of the United States successfully digging this canal with many of the same machines used by the French engineers. The difference is one of health of the men who dig the dirt. When the canal is finished thanks can be given to those medical men and engineers who recognized the practical value of preventive measures.

"If the history of Rome, Greece, and Panama prove such a vital relationship between material prosperity and public health, why should not this relationship exist here among ourselves? Who can measure the baneful effects of malarial fever and the hookworm on the South? Who knows but that the changed expression of 'Go West, young man,' by Horace Greeley, to the newer, and, to us, better expression, 'Go South, young man; go South,' is not due in a measure to an unconscious awakening and stimulation brought about by the hope of eradication of these diseases? Granting, then, that the commercial and social prosperity of our people depends in a great measure on improvement in public health, let us con-

sider the question of practical measures to reach this end.

"There is a difference between the legislative and executive measures applicable in a place like Panama and in our own territory. One is, in a way, under military rule; the other is controlled directly by the voice of the people. Though scientific laws teach us the exact measures to be followed, statutory laws and their execution depend on the persons who have power to make them. Under military regulations it is possible to enforce certain measures within a period of time not possible under a democratic form of government. Havana could not have been so effectually cleaned up if left to the municipal vote. I have been told that many of the natives are ready to turn back to their old unsanitary customs. Under a form of government like ours, however, we must depend on an enlightened public. Our lawmaking bodies must be made to understand that natural and scientific laws should be their guide in making statutory regulations.

"Though a constant agitation of these questions will have some good effect on our present generation, we cannot hope to reach ideal conditions or even fair conditions until our representative citizens are trained in a scientific manner to know the importance of scientific sanitation. We must look, then, to our schools.

"Youth is the plastic age of man. The teachings of childhood so imprint themselves upon the individual that his whole future life is influenced by them. When right, these teachings become, as it were, part of the individual, and to change them is an impossibility. When wrong, they are accepted as true until manhood and the age of independent thinking, when the individual is filled with doubt, and a conflict between truth and error takes place. So great is the tendency to cling to childhood impressions that it sometimes takes a long period for right to assert itself in the individual. When multiplied by numbers of individuals, we have what is commonly known as a persistent clinging to old ideas and false doctrines by the public. It is manifested by apathy and indifference by society, just as it was manifested in the sad instance mentioned above.

"In our schools, training should begin in the first grade and instruction should be continued throughout school and college life. This teaching and training should have a twofold purpose; first, to make healthy individuals; second, to make

right-thinking citizens as future lawmakers—to make citizens whose statutes will be based on scientific and natural laws.

"To make healthy individuals of our school children means that a development of medical inspection in our primary schools is necessary. This is important, since the school is the only governmental department that directly assumes control of children's lives. In America at least nine-tenths of our children are subject to this control, which is maintained, roughly speaking, during the critical years between 7 and 15.

"Medical inspection is founded on a recognition of the close connection which exists between the physical and mental condition of the children, and the whole process of education. It seeks to secure ultimately for every child, normal or defective, conditions of life compatible with that full and effective development of its organic functions, its special senses and its mental powers which constitute a true education."—Gulick.

"A distinction should be made between medical inspection for the detection of communicable and contagious diseases and physical examination for the detection of various defects of the special senses and of bodily abnormalities. The first is for a direct protection to the community; the second for securing and maintaining a healthy individual. According to Gulick and Ayers, medical inspection for detecting contagious diseases can only be conducted by the department of health, or at least with its active co-operation, because of the necessity for legal authority for protecting the community, not only during epidemics of contagious diseases, but also to prevent them.

"Effective physical examination can only be conducted by the board of education, or at least with its full co-operation, because it involves the following of the child from grade to grade, and from year to year. It involves the constant attention of the teacher with reference to such questions as seating the deaf where they can hear best, and those having poor vision where they can see best, as well as constant co-operation with parents.

"Closely allied to medical inspection is the supervision of the physical growth of the child through work and play. We will not discuss here the question of physical development through manual labor. We do not know what the future will bring forth in farm work, etc., in our primary schools, but at its best the work will be more or less mechanical. All labor in modern times tends to

the mechanical, and our great manufacturing establishments of all kinds will in the near future have to supply outdoor playgrounds for the physical exercise of their employees. Some of them are already doing this. This tendency to mechanical work means a readjustment of the physiological functions of the individual in his relations to society. We have only to go back about one hundred years when for all time before the bulk of the world's work was done by human muscle. In the golden age of Greece—the age of Pericles—eight out of every ten of the people were slaves who labored. These conditions have changed. The bulk of the world's work is now not done with either human or animal muscle. Man has harnessed the great powers of nature. At this time the small stream and babbling brook are even made to give up some of the energy they have for centuries been wasting. The farmer uses them to light his house, to cook his food and even to milk his cows. Electricity, gas and steam have taken the place of brawn.

"To develop the physical man and woman of the future, we must resort to the other agency—play. The narrow critics who have tried to put the ban on modern games in colleges and schools have unconsciously delivered a blow to the very cause they were trying to help, viz., the development of the future citizen. We must not forget that '*mens sana in corpore sano*' is just as true today as it was when first spoken. We as medical men should encourage this truth and incidentally encourage the acquirement of more and better playgrounds. This should be done now, for if we wait, even our small towns and villages will before long experience the same difficulties as our larger cities are at present experiencing in purchasing such grounds.

"Play, through school and college life, should be controlled by the institutions themselves. The physical directors should be educated men and take equal rank with men who teach in other departments.

"We come now to the didactic teaching of health questions in our schools and colleges—to the teaching of preventive medicine. This phase of the problem has in the past been almost totally neglected, both in our primary schools and higher institutions. A practical application of the simple measures necessary to prevent some of our most common preventable diseases is either thoughtlessly or ignorantly neglected in the communities

of most of our leading institutions of learning. As examples, let me cite the following: In a certain leading college in this State the horse stable belonging to the president of the institution is kept in the same way that stables were kept before science taught they should be regularly, thoroughly cleaned in order to prevent the growth of flies. In a certain high-school community the dairy controlled by a boarding-house for the students is just as bad as were the dairies in antebellum days when nothing was known of the scientific reasons for clean milk. This is nothing less than a disgrace. When our leading institutions pay no attention to these things, how can we expect the rank and file of our citizens to think of them? How can we expect to help the underman who makes it possible for the wheels of commerce to keep turning and who, with the help of machinery, supplies the energy in the work of the world? Unless we teach by precept and example the measures for the prevention of disease to our school children and to our students we cannot hope for a more rapid advance in the future than we have had in the past.

"The application of measures for the prevention of diseases must be made by the public. The application of measures for the cure of diseases must be made by the medical man. In prevention the public cannot apply rational measures unless taught why and when, any more than the medical man can apply rational methods in the cure of a disease when he is ignorant of its nature.

"We need not discuss here detailed plans for work. However, the work should be graded and should continue through school and college life. The courses in hygiene, sanitation and the prevention of disease should be given the same attention as the courses in mathematics, history or English. In this way, and in this way only, will we eventually have an intelligent and healthy public.

"So far we have spoken only of that phase of the child's relation to public-health problem that concerns its training and teaching. There is another phase, however, that is of vital importance, namely, its nourishment. This brings us face to face with the poor, and reminds us of the evils inflicted upon children of the thousands of toilers in our large cities who do not receive those elements of nutritious food which are necessary to a wholesome physical life. Mr. John Spargo of New York has dwelt upon the subject in his valuable book, 'The Bitter Cry of the Children.' It is

true that conditions are vastly better than they were in the eighteenth century in England, when men actually 'trafficked' in child slaves and made a profitable business supplying children to the manufacturers. These children were then half clothed and fed and made to work like animals. Though no such conditions would be tolerated today, still we have conditions which show a maladjustment of our means to our social needs. We have those conditions which in the light of modern scientific knowledge makes it the sacred duty of the men who control the capital of our country to see to it that the children of the men who work for them have proper food and good sanitary home surroundings.

"Though the problem of nourishing food is not so difficult in the South as in some of our modern cities, the preparation of the food for the table and the sanitary surroundings of many homes of the laboring class need especial attention. At the present time there is a tendency to build large factory villages in the South. These villages are for the most part controlled by the mill owners. That everything is not done in all cases to safeguard the inhabitants of these communities against preventable diseases is shown by the following facts: In a certain mill settlement of North Carolina the mill owners are building two open privies, a stable and feedroom under one roof. The stable is presumably for a cow. During a recent visit to this village I saw dozens of houses built on this plan. The only one examined showed a dirty cow stable in direct communication with the space beneath the seats of the closets. What ideal conditions for transmitting typhoid fever! Think of it, the open milk bucket (there will be many of them), the breeding place for flies, and a prolific source of typhoid germs, altogether. This is a grave injustice to the people who must live in that community and who are ignorant of the invisible danger that lurks at their doors. It is an injustice by the mill owners, who owe it as a sacred duty to employ expert advice in the planning of their mill villages just as much as in building their factories and installing their machinery. It matters not how much they may desire to surround their employes with home comforts, they should not do so at a sacrifice of modern sanitation. The only safeguard against such a sacrifice is expert advice and supervision.

"In regard to child labor, our manufacturers should see to it that no child shall work to his future hurt. Homer Folks, Commissioner of Charities

of New York, says: 'The objection that is offered most frequently and perhaps with most effect to further the restriction of child labor is the alleged fact that in a great many instances the earnings of these little children are needed to supplement the income of widows of families in which the wage-earner may be either temporarily or permanently or partially disabled, and without the small addition which the earnings of these little boys and girls can bring in there would be suffering and distress. It would be easy, I think, to overestimate the extent to which that is true. So we should not admit that that side is more serious than it is, but do let us cheerfully, frankly and gladly add that there would be many cases in which the proposed legislation (for the restriction of child labor) would deprive many families of earnings from their children, and that we propose ourselves to step into the breach and provide that relief in good hard cash that passes in the market. If larger means are needed to support these little children so that they need not depend on their own labor, by all means let us put up the money and not push their children for a part of their support before the time when they should naturally furnish a part of their support. In the long run, it is never cheap to be cruel or hard. It is never wise to drive a hard bargain with childhood."

"We should remember this relation of childhood to public health. We should not forget that hardships placed upon our children today will be borne by society when they grow up.

"There is a sacred something on all ways,  
Something that watches through the universe:  
One that remembers, reckons, and repays,  
Giving us love for love and curse for curse!"

## ITEMS

Dr. Louis Elsworth Langley, class of 1910, of Williamsport, Pa., was a recent visitor to the University Hospital.

As this issue goes to press Academic Day exercises are being held, November 11, 1910. A full account of the program will appear in the next (December) issue.

Dr. Frank Lynn, class of 1907, formerly assistant resident surgeon in the University Hospital,

and at present assistant in pathology at the University of Maryland, has established himself in practice at 1619 St. Paul street, Baltimore, Md.

Dr. Claud Clarence Smink, class of 1909, is medical superintendent of Bayview Hospital.

Dr. Howard J. Maldeis, class of 1903, performs the Wasserman reaction every Wednesday in the University Hospital.

Dr. Arthur Louis Fehsenfeld, class of 1909, formerly resident physician in the insane department at Bayview Hospital, is located at Forest Park, Md.

Dr. Alexander C. Abbott, class of 1884, professor of bacteriology in the University of Pennsylvania, recently delivered a course of lectures on "Preventive Medicine" at the University of Maryland.

Dr. Horace Melville Simmons, class of 1881, is visiting in Detroit, St. Louis and Chicago.

The following eulogy was delivered by Attorney E. H. Morton at the grave of Dr. John Morgan McLaughlin, class of 1888, of Webster Springs, W. Va., who died August 19, 1910:

"Sometimes from the pulpit we preach sermons like the easy flow of the crystal river; sometimes from the hustings with an applauding populace we speak with pleasing words and grave, or in the crowded courtroom we plead with zeal and convincing force, but when in the presence of death we would fain pay a last tribute to a departed friend, our words take the wings of the morning and fly away.

"For over 20 years Dr. McLaughlin and myself have been friends. I have been his patient, he my client. Many a home represented here this evening feels keenly the loss sustained in the death of our friend and neighbor. Only those who knew him most intimately understood and loved him best. It was the largeness of his heart, the nobility of his character, his unquestioned ability as a physician, his love of his profession and his sympathy with the suffering that made him a man standing erect above his surroundings.

"The passing of this man's life is as a summer sunset at midday, so strange the workings of Providence that death should be permitted to se-

lect as his victim the most useful of us all, but 'Heaven gives its favorites early death.'

"'Leaves have their time to fall  
And flowers to wither at the North wind's breath,  
And stars to set—but all,  
Thou has all seasons for thine own, O Death.'

"Only is a life noble to the extent that it works and sacrifices for others. I firmly believe that our reward in Heaven will be given according to our service to men; that the everlasting sunshine and never-fading flowers of God's paradise are for those only who have made sunshine and caused fragrance in the lives of others here.

"But I am asked to speak of him who has entered upon that long, sweet sleep that shall find its waking in a world everlasting—that mysterious clime where dwell the myriad millions of ages past—that land to whose shores the living multitudes are rushing in a maddening race.

"Flattery for the dead is wasted words. But the story of a noble life should be as bread cast upon the waters, that the living feeding upon it may grow and be strong. I therefore tell no idle story of false virtues of my friend, whose lips shall never again speak words in my defense.

"For over 20 years the lifeless form now peacefully resting upon death's pillow has gone in and out before you. His was a mission of mercy, and well did he fill it.

"Many a mother's tears dropped in sorrow while anxiously bending over her aching child have been dried by his skill and care. The sadness of many a home has been turned into joy by the sympathetic ministrations of this wonderful healer.

"Over hill and mountain, across glade and glen, through rain and storm, in burning suns and biting frosts, night and day, to the aged, the young, the poor, the penniless, to us all, with hurried steps has this physician come at our call, and oft without money and without price. In his care, with confidence, we have trusted the lives of our loved ones. Miss the going of such a one? Yes. Forget the footsteps of that one whose coming meant relief to our sick and a soothing to our sorrows? Never!

"Over 1900 years ago the Great Physician hung, dying. His enemies in scorn and derision cried, 'He saved others; himself he cannot save.' It required the death of the Savior of the world to prove that he was divine. So, in the death of Dr. McLaughlin will there be brought forth and demonstrated to friend and foe the true greatness

and worth of the man. In the loss by his death will be proven the value of his life.

"When the Son of Man shall come in his glory and the holy angels with Him, and He shall sit upon His throne, and before Him shall be gathered all the nations, when He shall divide the sheep from the goats, Dr. McLaughlin will be among that number who shall sit upon His right hand, and his Master shall say unto him, 'I was sick, and ye visited me.' Then shall he answer, 'Lord, when saw I thee sick and came unto thee?' And the King shall answer him and say, 'Verily, I say unto you, inasmuch as you have done unto one of the least of these my brethren, you have done it unto me.'

"What a promise, what a truth! Man serving man, ministering his regard in Heaven. Monuments which we build of service and sacrifice are more beautiful and enduring than those of granite and marble. They pierce the heavens and are baptized with the dews from the throne of God.

"One by one God is taking man from this earthly growing and transplanting him into that mystic clime, free from the winter's storm and the summer's blight.

"Yes, how frail the foundations on which we build our earthly hopes and aspirations. However fond the dream or bright the vision, all must vanish and give way to the omnipotent power of Providence. The brightest flowers that bloom in life's garden are often blighted by but a single zephyr blown from the hills of God. He who knows it all knows best.

"Dr. McLaughlin was a friend firm as a rock. The kind who stood firm while others forsook and fled. He never betrayed your confidence, and expected the same fidelity of you. To my mind there is nothing more beautiful or grander than a friend standing firmly, with encouraging words, while the shafts of calumny are hurled at you by the cruel hand of an enemy.

"This death has peculiar sadness. After years of toil and preparation, Dr. McLaughlin was entering upon the most useful period of his life. Thoroughly equipped and qualified, he had gained for himself a reputation as a physician that was not confined even to the borders of his own State.

"Only a few short months ago some of us gathered at the bridal chamber and witnessed the entering of our friend upon that domestic life which promised happiness, contentment and joy. How suddenly those hopes and aspirations were ended.

'If friends grieve, what must be the gloom into which she has gone whose fate to his for life was joined.'

"To that one whose life was united to his I give this sentiment as a solace:

"'For life to me is a station

Wherein apart a traveler stands—  
One absent long from home and nation  
In other lands.

And I, as she who stands and listens,  
Amid the twilight's chill and gloom,  
To hear, approaching in the distance,  
The train for home.

For death shall bring another mating,  
Beyond the shadow of the tomb;  
On yonder shore, a groom is waiting  
Until I come.'

"In the name of thousands of midnight battles fought and won, in the name of thousands of unshed tears and forestalled pain, in the name of many children saved to their parents, and of the many parents saved to their children, we commit all that is immortal of Dr. McLaughlin to the loving care of the Saviour."

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Dr. W. Cuthbert Lyon, class of 1907, first lieutenant M. C. R., U. S. A., has contributed a paper entitled "Venomous Snakes of the United States, Their Bites and Treatment," to the November (1910) *Southern Practitioner*.

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We are glad to report that Dr. Oliver Parker Penning, class of 1897, who has been in ill-health for the past summer, has so far regained his health as to be able to resume his practice.

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Dr. Paul W. Greene, class of 1900, is located at Phoebe, Va.

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Dr. James Finney Magraw, class of 1909, is located at Perryville, Md.

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Dr. George Albert Parker, Jr., class of 1910, passed the State Board of Pennsylvania in June, and is now resident physician in Germantown Hospital, Philadelphia, Pa.

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Dr. Edgar G. Ballenger, class of 1901, has a paper entitled "Review of the Reports of the Use of Ehrlich's New Remedy for Syphilis" in the Oc-

tober number of the Atlanta *Journal-Record of Medicine*, of which Dr. Ballenger is editor. Dr. Ballenger is now in Germany, studying the technique of the Ehrlich treatment.

Dr. James A. Nydegger, class of 1892, surgeon U. S. P. H. and M. H. Service, was detailed to represent the service at the meeting of the Medical Society of the State of Pennsylvania, held in Pittsburgh October 4-6, 1910.

Dr. Cooper R. Drewry, class of 1902, and Mrs. Drewry entertained at a Hallowe'en dinner at the Pot and Kettle Club in Baltimore county, Maryland.

Dr. Edson W. Glidden, Jr., class of 1907, has resigned as assistant superintendent of the Maryland Tuberculosis Sanatorium to accept the superintendency of the new Georgia State Tuberculosis Sanatorium.

Prof. John C. Hemmeter is giving a course of special lectures on "Nutritional Therapy" at the University of Maryland.

At a recent meeting of the Anne Arundel Medical Society the following resolutions were adopted:

"*Resolved*, That the members of the Anne Arundel County Medical Society refuse to make examinations of 'insane persons' for less than a fee of \$10."

"*Resolved*, That after January 1, 1911, no member of the Anne Arundel County Medical Society shall do or perform any contract practice."

Among those present were Drs. H. Baldwin Gantt, class of 1880; Charles R. Winterson, class of 1871; Frank H. Thompson, class of 1879; Jesse Oliver Purvis, class of 1904; Walton Hopkins, class of 1904, and Louis B. Henkel, Jr., class of 1903.

Prof. Charles Wellman Mitchell, class of 1881, professor of medicine and diseases of children in the University of Maryland, has just returned from a trip abroad, and has the following to say of the Germany of today as compared with the Germany of his student days, 25 years ago:

"I spent three months in Germany, Austria and France this summer with my wife and children, and, while I did not enjoy my stay as much as I

did my visit of a quarter of a century ago, I was impressed with the fact that Germany is the center of European development, at least commercially, but it has lost its old attractiveness and quaintness.

"I traveled extensively all through the country, and scarcely does one pass out of one city before another comes into view. In one section I rode a hundred miles and never passed out of sight of a smokestack. The Germans are workers, and they make every man count. I was in Berlin a large part of the time, and was never accosted for alms, nor did I see a beggar on the streets. This is due to the fact that everybody is at work who can raise a hand, and those who cannot are receiving pensions from the Government, which they themselves paid for in weekly instalments, according to law. It is a wonderful system, and exemplifies the beauty and meaning of the paternalism which rules the country.

"Art, of course, is not being developed, and will not as long as the craze for trade continues. The evidence of this is found in the monuments recently erected, where enormous expenditures resulted in too much embellishment and the central figure is generally hidden from view.

"But great strides have been made in all directions, and the contrast with the balance of Europe is striking. The streets and roads are the best, and policing and lighting are nearly perfect.

"The people are not downtrodden, as often stated, though the taxation is burdensome. This is due in large part to the policy of military readiness of the Government. Every town of a thousand persons has its arsenal and garrison, and Germany's navy is going to be the finest in the world. The railway system is better than our own, and safer. The mobilization of troops is made the central idea.

"Germany is spreading its commerce all over the world, and South America and Africa especially are feeling the impress of German activity.

"Germany has taken up the bustle and hustle of America. The comparison of England and Germany shows the latter more active, progressive, and perhaps better governed. In England suffering is intense, and Parliament is at a loss to alleviate conditions."

Dr. Hugh Brent, class of 1903, who has been engaged in medical work in the Amazon regions, will return home on a furlough the early part of the coming year. Dr. Brent says he desires \$300

worth of American beefsteak ready for him when he strikes New York.

Dr. R. Dorsey Coale, Dean of the University of Maryland, is in receipt of the following letter from Dr. Moussa Hassoun, class of 1901:

Khartoum (Sudan),  
Khartoum General Civic Hospital,  
September 22, 1910.

R. Dorsey Coale, Ph.D.,  
Dean of the University of Maryland,  
Baltimore:

Dear Dr. Coale—It is with deepest regret I have to carry you the following sad news of the murder of our dear confrere, Dr. Tewfik Rassi, a graduate of your University.

Poor Rassi was stabbed on the second of this month at 8.30 P. M. at Kodok with a spear in his back. The spear cut the right kidney, part of the intestines, and stopped by being bent in hitting the right ilium. The poor doctor died at 4 A. M. the following morning, after seven and one-half hours of agony. No medical attendance was available on the spot, as he was the only medical officer in the station. No clue to the murderer, yet.

Dr. Rassi did not see the murderer even, as it was pitch dark that night.

I understand that the University has been issuing a medical paper for some time back. I should be greatly obliged if you will kindly send me one or two numbers.

Hoping this will find you in the best of health, I remain,

Yours very sincerely,  
MOUSSA HASSOUN.

Dr. Howard Steele Holloway, class of 1903, of Jacksonville, Fla., was a recent visitor to Baltimore.

The General Alumni Association held a buffet luncheon and smoker in Davidge Hall, Lombard and Greene streets, November 11, 1910, at 8.30 P. M.

### ENGAGEMENTS

The marriage of Dr. Graiville Hampton Richards, class of 1908, of Port Deposit, Md., to Miss Mary Emma Wright of Calvary, Md., will be celebrated the latter part of this month.

The engagement has been announced of Dr.

Russell Wesley Raynor, class of 1908, of Vienna, Md., and Miss Lola E. Wilson of Deal's Island, Md. Miss Wilson is the daughter of Mr. and Mrs. Edgerton G. Wilson. The wedding will take place November 16, 1910.

Mr. and Mrs. Thomas Biscoe Gourley of Holland Point, Calvert county, Maryland, have announced the engagement of their daughter, Miss Anna Cary Gourley, to Dr. James Dawson Reeder, class of 1901, of Baltimore, Md. The wedding will take place the latter part of December, 1910.

### MARRIAGES

Dr. Emile Bonniwell Quillen, class of 1905, was married to Miss Leila Griffith Owings, class of 1905, University Hospital Training School for Nurses, at the Church of the Ascension, Baltimore, Md., Tuesday, October 18, 1910. Dr. and Mrs. Quillen will be home after the 20th of November at the Carolina, Wilmington, N. C.

Dr. Hoagland Cook Davis, class of 1902, was married to Mrs. Katharine Carroll Dowell of Baltimore Wednesday, October 19, 1910. Mrs. Dowell is the daughter of Mr. and Mrs. William C. Carroll of Baltimore. Dr. Davis was formerly of North Carolina, and after graduating from the University of Maryland was for some time resident physician of the Presbyterian Eye, Ear and Throat Hospital of Baltimore. He then engaged in private practice, and has been most successful in his special line—nose and throat work. He is chief of clinic to the professor of diseases of the nose and throat at the University of Maryland, and is one of the most popular of the younger members of the staff of the University. The wedding took place at the home of the bride's parents, 1717 Park Place, in the presence of the immediate families of the contracting parties only, and was followed by a small wedding breakfast. The ceremony was performed by Rev. T. J. Broydick, pastor of St. Martin's Catholic Church. Dr. and Mrs. Davis left immediately after the ceremony for a trip to Hot Springs. Upon their return they will live at the Plaza, Park Place, where they will be at home after December 1.

Dr. Joseph Howard Hodges, class of 1908, of Harper's Ferry, W. Va., was married to Miss Edna Belle Hendricks, daughter of Mr. and Mrs. M. Brown Hendricks of Duffields, W. Va., at noon

Wednesday, October 12, 1910, at St. Peter's parsonage, Harper's Ferry, W. Va., by Rev. J. E. Collins. The ceremony was witnessed by a few close relatives and near friends of the bride and groom.

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Dr. Benjamin H. B. Hubbard, Jr., class of 1895, of Whitestone, Va., was married to Miss Lloyd Estelle Betts Smith at Sunnyside, Heatsville, Va., October 11, 1910. The marriage was witnessed by members of the families of the contracting parties only. The couple will live in Whitestone, Va.

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The marriage of Miss Mary Cunningham Ashby, daughter of Dr. Thomas A. Ashby, class of 1873, to Mr. Julian George Randolph Graham of Chicago, took place at the residence of the bride's parents, 1125 Madison avenue, Baltimore, Md., October 7, 1910. The ceremony was performed by Rev. De Witt Benham, pastor of Central Presbyterian Church. The bride was given in marriage by her father. Miss Ashby is a member of the Woman's Auxiliary of the University Hospital.

## DEATHS

On September 2, 1910, at Kodok, Egypt, Dr. Tewfik T. Rassi, class of 1902. Dr. Rassi was assassinated by an unknown native. He was stabbed in the back with a sword, the blade piercing his right kidney and intestines. He was a surgeon in the Egyptian army. While in America Dr. Rassi distinguished himself as a student.

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Dr. Joseph Luciano Romero, class of 1879, of 2109 Kerschell street, Jacksonville, Fla., died at his home Friday, October 14, 1910. Dr. Romero was a native of Cuba, and was born at Matanzas January 7, 1853, the son of Joseph and Maria Francisca Polledo Romero, of Cuban ancestry. Dr. Romero was educated at private schools in Matanzas and at Irvington Academy, Irvington-on-the-Hudson, N. Y.; Amenia Seminary, Amenia, N. Y., and finally at the University of Maryland, where he graduated in 1879. He entered private practice in Baltimore, but in 1885 removed to Lavilla, Fla., which is now part of the city of Jacksonville. Dr. Romero enjoyed an extensive private practice, and also filled the positions of health officer of Lavilla, 1885; sanitary inspector for Duval county, 1886-7; health officer for Jacksonville, 1895-97; member of the Jacksonville City

Council, 1901-1903; Cuban Consul at Jacksonville from 1905 until his death, and for a time served in the surgical department of the United States Navy. During his residence in Baltimore Dr. Roniero was a member of the First Baptist Church. He married Miss Margaret Gale Merchant of Mathews county, Virginia, who died in 1905. He is survived by a son, Eugene Albert Romero, and a daughter, Juniata Margarita Romero.

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Dr. George C. Worthington, class of 1866, died at his home in Alberton, Baltimore county, Maryland, October 23, 1910, of cirrhosis of the liver. Dr. Worthington was 66 years of age.

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Dr. John M. B. Rogers, class of 1877, died at the home of his sister, Mrs. Philips, of Govans, Md., of typhoid fever, October 30, 1910. Dr. Rogers was born near Beltsville, Prince George's county, in 1855, and received his primary education in the public schools of the State, graduating later in medicine at the University of Maryland. Dr. Rogers was the son of the late Mr. and Mrs. John Rogers, his father being a naval officer and a native of Virginia. His mother was connected with the most prominent families of Southern Maryland. Dr. Rogers practiced for a short time in Beltsville, and later removed to Clarksburg, Howard county, where he remained for 10 years, finally locating in Ellicott City, practicing here until his death. He was very popular through the county, was thoroughly interested in politics, a loyal Democrat, and took active part in county and State elections. Dr. William B. Rogers of the medical staff of the Baltimore & Ohio Railroad is a brother. Interment was in Greenmount Cemetery, Baltimore, Md., November 1, 1910.

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Dr. Charles Dix Eichelberger, class of 1868, died at his home in Emmitsburg, Md., October 19, 1910. Dr. Eichelberger was 75 years of age, and spent his entire life in Emmitsburg, his father, Dr. James W. Eichelberger, and grandfather, Dr. Jos. Eichelberger, having also been physicians of that place. His brother, Dr. James W. Eichelberger, is also a graduate of the University of Maryland, class of 1870, and also practices at Emmitsburg. Dr. Eichelberger was a member of the Lutheran Church, and an ardent Republican. He is survived by his brother and two sisters, Mrs. Mary E. Ehrechart and Miss Marian Eichelberger.

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No. 10

## SOME THOUGHTS ON UNIVERSITY EDUCATION IN THE UNITED STATES.

AN ADDRESS ON ACADEMIC DAY OF THE UNIVERSITY OF MARYLAND, NOVEMBER 11, 1910.

By CHARLES J. BONAPARTE.

*Young Gentlemen of the Several Schools,*

*Ladies and Gentlemen:*

The purpose of our meeting this morning is to remind ourselves and others of the gravely significant fact that all branches of this old and honored society of teachers and scholars form part of a definite and harmonious whole; that, in short, we constitute an American university. It is not altogether surprising that we and others may sometimes need this reminder, for an American university is still a novelty. When I grew to manhood it was, if not unknown, only a matter of interest for students of institutional embryology. No one who has given thought to the subject and who knows enough about it to think to any purpose can doubt that during the past 40 years the university as a new force has now come into the moral and intellectual life of the American people; it is no less certain and no less obvious that of this force there was but a very faint foreshadowing 40 years ago.

I am, of course, aware that, long before that time, "universities" were thicker than hops in some parts of the country; indeed, the name "university" was once a very common designation among us for a big building devoted to some sort of school purposes, although it was usually a matter of mere chance or of the founder's taste that this had not been styled instead a "college" or an "academy," a "seminary" or an "institute." I suspect that the number of nominal universities in the United States has rather diminished than increased during the past 40 years, although I have no statistics on the subject; but the question is of as little practical importance as might be an inquiry into the supply of hobby horses in our toy stores were we at war and seeking to remount

our cavalry. That a university would not come into being when a high school or a college, or even a professional school, received the title was a truth too obvious to have awaited discovery until then, and there had already appeared, in what have since become our leading universities, embryonic features of their future development. Harvard and Yale and several of their sisters were already more than overgrown colleagues, and the clear-sighted saw that they would surely grow more and more unlike what they had been and, in time, emerge from their transitory and amorphous conditions into definite and relative permanent shapes. Nevertheless, that a young man might go through a college or professional school, that he might even go through a college and a professional school, and yet have received no university training whatever, was, to a large majority of Americans, even of educated Americans, a suggestion altogether strange and paradoxical 40 years ago. It is true that a partial and uneasy perception of the fact was beginning to work in the public mind, and had led, here and there, to some faltering first steps toward provision for a need thus imperfectly felt. Shortly before that time two post-graduate scholarships had been established at Harvard, attracting, as I well remember, far more attention and comment than does now the existence and prosperity there of its great Graduate School. How unfamiliar to the American public was the idea of any endowment for advanced study or original research is curiously illustrated by the interest then excited by this rudiment of such an endowment, especially when we contrast with it the general and complacent acceptance by the community of vast benefactions to the same ends today as almost matters of course.

But yet more noticeable and, for our purpose, far more important has been the rapid growth among those entitled to speak with authority of a general belief that studies of any kind may provide a liberal education if prosecuted according to liberal methods and with a view to liberal

ends. This is strikingly illustrated by the profoundly changed attitude of an enlightened public opinion toward professional schools. The builders-up of our young universities have steadily and persistently pursued two ends with respect to graduates of such schools—to make them all, in fact, men of liberal education and to have them always and everywhere thought of and treated as men of liberal education. Now, when I was a student in Harvard College, the law, medical, divinity or scientific students there were generally known in the undergraduate world as "pills" and regarded as mere crammers for a chance to prey upon an unwary public; nor, I must say, was this opinion as altogether absurd and unjust as it must now appear: too many of them were then, in fact, men of imperfect information and coarse ideas and associations. Even during my 12 years' service on the Harvard Board of Overseers some of my very estimable colleagues sometimes seemed, at least to my mind, to think of professional students and the alumni of professional schools as the "pills" of their own college days; but all enlightened men now fully recognize the immense change which the past 35 years have wrought in well-nigh every feature of professional education at Harvard and elsewhere, and the complete and most salutary transformation, not only of the professional schools there, but of similar schools throughout the Union as well, is due, most of all, to the birth and growth of real American universities.

An American university must have two qualities to live and deserve its name—it must be a university and it must be American. Simple and almost self-evident as this proposition may appear at first sight, neither of its branches has escaped practical contradiction. On one of the Johns Hopkins commemoration days a number of years ago I listened to an interesting address by a very eminent man, at the time chief officer of a well-known seat of learning, on the best kind of university for our country. He pointed out that in England, in France and in Germany the name was given to entirely different institutions, and, after more or less discussion of their respective merits and shortcomings, decided that, of the three types, the last was best suited to our needs, and advised us to reconstruct our present universities and construct those of the future on a German pattern. Now, to my mind, German universities, when good of their kind,

are good things for Germans, as are English, under the like conditions, for Englishmen. If we intend our sons to be subjects of Kaiser Wilhelm or King George and their respective successors, by all means let us send them to be trained as such subjects where training to that end is most thorough and effective. If, however, we mean them to be genuine Americans, and I think this is what we mean if we are ourselves genuine Americans, and not shabby counterfeits of foreigners, we must either give them university education in a genuine American university or give them no university education at all.

Two generations since we had so generally adopted the second alternative that, with few exceptions, we were unconscious of the fact. At that time the average American was but beginning to outgrow the notion that an institution of higher education meant essentially a large building. During the acrimonious controversy occasioned some 30 years since by the refusal of the Johns Hopkins Trustees to remove the University to Clifton, a newspaper writer, who strenuously advocated the change, exclaimed indignantly: "Johns Hopkins intended to found a university, not a little dayschool!" Apparently this person's lucid and adequate conception of a university identified it with a big boarding school, and it must be admitted that this view was seemingly shared by many others. Acquaintance during the intervening years with some real universities has by this time convinced the American people of the truth, in educational matters as in others, of the adage that "a dog won't have five legs, even if you do call his tail one;" or, in other words, that if we dub a grammar school or a high school or a college a "university," the facts will be unchanged, no less certainly than, if the Athenians had taken seriously Socrates' sarcastic advice, and resolved that their asses should thereafter be horses, the ears of the beasts would have grown no shorter. And with this conviction has come a recognition of the fact, which some have at times affected to ignore, that those who can, in the nature of things, receive the really higher education must be, in our time and country, as they have been always and everywhere, the leaven hidden in three measures of meal, a ferment vital to civilization, but numerically a small minority of the community.

What is it, then, which distinguishes from others those thus trained? In other words, what do

we mean when we say a man has had a liberal education? When I was a boy teachers of the higher education everywhere were already wrestling with a problem for which it has become each day since then more difficult to find a satisfactory solution. This was how to find time, within the years which can be given to teaching, to teach a boy all that a man should be taught. The traditional curriculum of liberal studies had slowly changed, and, on the whole, slowly expanded, but it was, in essentials, the same 100 years ago which it had been 300 years previously. Within the past century, however, it has been so flooded with novelties as to be completely revolutionized, and five-sixths of this revolution has been effected within the past 50 years. The prodigious and constantly increasing rapidity with which new inventions and new discoveries have extended the sum of human knowledge makes it every day more obviously impossible for any man, whatever his powers or his leisure, to master thoroughly all or even many branches of a liberal education. He simply must neglect some to some extent if he is to study any to any benefit, and it has become not merely urgent, but indispensable to answer the question how a limited course of studies can be made fruitful of a liberal training.

It is, however, none the less true now than it always was that the whole value of education, even the possibility of enlightenment, depend—indeed, these are now seen every day more clearly to depend—upon the distinction between *partial* and *superficial* knowledge.

That "a little learning is a dangerous thing" is no less true today than it has ever been. In a sense it may be said to be now more, or, at least, more manifestly, true, for the experience of the race has been enriched by many painful illustrations of that "*caveat of fools*," knowing enough and little enough to make their ignorance dangerous, against which the poet warns us, since his warning was given. And yet "a little learning," a *very* little learning *indeed*, is all that anyone, even a specialist, can now acquire in any one branch of knowledge, and every day, as men of research read more and more of Nature's riddles, the discrepancy between the acquirements of mankind and the possible requirements of any individual becomes more grievous and more glaring. In old manuals of political economy we were told how 18 distinct processes, each entrusted to a different workman, were employed

in fashioning the head of a pin. One of these workmen, after years of practice, might, perhaps, claim a thorough and exhaustive knowledge of so much learning as concerned his daily labor, to be fully educated to the end of making the eighteenth part of a pinhead; but the claim would be worse than doubtful, for the discovery of a new metal, the invention of a new tool, the utilization of a new force, might tomorrow make all he knew as practically useless and irrelevant, even to his own minute ends, as any whimsical subtlety of the schoolmen. Let us suppose, however, that his claim were conceded: would he and his like, that is to say, could human machines, each taught, thoroughly if you will, the one-thousand-millionth part of the mechanical work of a civilized society, and, perchance, as to all else, virtual savages, could such beings be fairly called men liberally educated—educated at all, or even civilized?

Fortunately, it is no less certain that "a little learning" may be both safe and wholesome. The poison lies not in its quantity, but in its quality. If a man has been so taught that he fully realizes the immensity of his own ignorance, and realizes this the better the more he learns; if the first fruit of his learning be, not a foolish conceit, but a wise humility, which shall daily deepen as he is taught daily to more clearly see at once how insignificant is all he can possibly learn compared to the sum of human knowledge, and how infinitesimal is that sum itself to the inconceivable mass of things knowable; if, in short, his education serves, or at least tends, to put him in his right place, and not to take him out of it, then, no matter how little his learning, it will do him good. Now, there is one sure test to distinguish between the two kinds. A man superficially taught must unlearn something before he learns more. Your training will be sound and thorough, so far as it goes, provided that upon it, as a safe foundation, with no change or waste, you can immediately rear a superstructure of higher knowledge.

The recognition of this truth has caused it to be generally accepted as a principle of American higher education that the "humanities" now include all studies, whatever their subject-matter, which really widen the mind, refine taste and strengthen character, and that any form of advanced study may bring these fruits of a liberal training if pursued according to liberal methods and in furtherance of liberal aims. It does not

follow, as has been sometimes claimed, from this doctrine, that all studies are of equal intrinsic value for the ends of the higher education. The theory only regards their intrinsic value as outweighed by the method of their prosecution and the motive of their choice. It alleges *what* a man studies to be a matter not of indifference, but of less moment than *how* or *why* he studies this. And it recognizes more clearly and thoroughly than had been, so far as I know, ever before practically admitted, the sufficiently obvious truth that, inasmuch as one man cannot do his best in the same field of labor where another can do his, the same form of training may not be adapted to bring out the best which is in each of them. If to study Latin and Greek will best make of one boy as much of a man as may be allowed by the stuff in him available for such manufacture, then let that boy study the classics; if for another the same happy result will flow from time given to mathematics or physical science, let boy No. 2 be kept at the blackboard or in the laboratory. In either case the output may be either good or bad, a credit or a disgrace to the plant and the process; but these results will depend not on the studies chosen, but on their adaptation to the capacity and taste of the scholar and to the spirit in which they are prosecuted.

As I have already suggested, to my mind a very important, if not the most important, function of education is to put each man as nearly as may be in his proper place relatively to other men. In a primitive society the wise, brave and strong establish their right to leadership by what may be not inappropriately styled "knockdown arguments." This form of persuasion, though of undoubted efficacy, has two rather serious drawbacks. Its application usually involves more or less smashing of glass and china, or, in some other form, material waste and damage to the community, and it can be applied only by those in the maturity of their strength, so that a man must spend precious years of manhood in proving that he is fit to lead before he can lead in fact. As we have become less primitive we have sought to diminish the cost and advance the time of this process of natural selection, and to these ends we substitute, so far as we can, a struggle for leadership between half-grown men in schools and colleges for a similar struggle between grown men in after-life. It seems, to me at least, obvious that a contest of this nature will the better ac-

complish its purpose the more fairly all enter upon it; and, since the experience of mankind has shown that anyone does with least labor and most fruit what he likes to do, and obtains the greatest return with the least effort and fatigue from work in which is his heart, given that it is of minor consequence what a scholar studies and of vital moment that he study this, whatever it may be, earnestly and intelligently, the conclusion is reasonable, and, indeed, as it seems to me, inevitable, that his time should be devoted to studies which awaken his interest and harmonize with his tastes. Possibly he might in theory work to better advantage at something else, but if he will *work* at what he likes and only dawdle at what he doesn't like for truly educational ends his time will be used to good purpose in the former case and worse than wasted in the latter.

Now, no one knows what he likes so well as the man himself. Argument by those older and wiser as to what he ought to like is beside the question. It is the shoemaker explaining that the shoe can't pinch; he knows a great deal more about shoes than does the customer, but on the issue of pinching *vel non* the latter's verdict is conclusive and without appeal. A yet more accurate analogy is that of marriage. The girl that a young man wants may not meet the fancy of his mother or his aunts; I doubt, in fact, if she often does, and they and others may agree that his choice shows little wisdom and poor taste; but the very fact that it is his choice, that he does want her, constitutes a very strong reason why he should have her, or, at least, try to get her. So the fact that, a few years before, he was willing to do hard work in course A, while in course B he would only yawn and mark time, justified his electing A and dropping out from B, even though his father stood aghast and his uncle, the professor, grieved.

A good many years ago I knew of a prominent though somewhat eccentric gentleman who caused his children to eat habitually the most indigestible food because he wished to strengthen their stomachs through the performance of exceptionally difficult feats of "benevolent assimilation." He considered this an important branch of their education. His method cannot be commended without reserve, but his purpose was most reasonable. He could teach his children few things better calculated to make them happy themselves and useful to others than how to avoid dyspepsia. He

was a little before his time, however, for only within comparatively few years have the scientific training and the development of the body, not as a preparation for any form of manual labor, but as a branch of general education, attracted the attention they certainly deserve. Like every other good thing, this apparent novelty is in reality a revival of antiquity. The essentials of a Greek liberal education were gymnastics and music, and, although neither word was used in its modern sense, this classification sufficiently indicates how well the countrymen of Pericles and Aristotle recognized in the cultivation of physical health, strength and dexterity a legitimate end of scholastic training. *Sana mens in sano corpore* is the equipment of a youth for whom the best education has done its best, and it follows that, since a university training is the highest form of education, such a training fails in its full duty if it fails to strengthen and purify the body no less than the mind.

Young men, when you lose the care of this, your Alma Mater, you will need in very truth a sound mind in a sound body if you are to bear your just share of the burdens resting on American manhood and neither deny nor shirk them. A part, an important part, of the work each one of you will then begin will be that of his chosen profession; but, although a part, and although important, it will not be the whole of his work. Every member of a learned profession, every man gifted with a liberal education, owes a special, a peculiar duty to the sovereign whose laws have assured him the peace, order and security which make liberal studies and civilization itself possibilities, and it is of this part of your work, of the duty, resting on all of you alike, to advance the welfare by promoting the good government of your city or town or county, of your State and of the nation, that I shall speak briefly during my further trespass on your attention this morning.

This work is largely remedial. No community is, or ever has been, as well governed as it could be or should be, and the first step which a good citizen must learn to take, in seeking better government, is to tell the truth about existing abuses, to tell the truth without prejudice or exaggeration, but to tell it fully and fearlessly, and to ask resolutely and persistently the help of public opinion in righting these wrongs. This is the first step, a step which, like other first steps, sometimes "costs." Those who take it will often encounter

misconstruction, yet oftener misrepresentation and all the time abuse; but you can cure no evil in government or in society, can reform nothing, if you shrink from the enmity or the ill offices of those who live or profit by the evil, who are parts of the thing to be reformed.

This leads me to say that a condition, to my mind a vital condition, of good service to the State and happiness to yourselves is that, as to such things as these, you be not unreasonably or morbidly sensitive. I have heard that some people are born with no outer skin, and for them the least pin prick is a disaster. Many more people are morally in the like or in a worse plight. But such as they must take back seats in a work-a-day world. I have no purpose to decry that "decent respect to the opinion of mankind" asserted in our Declaration of Independence to be the motive for its proclamation, but if a man be indeed a man, respect for his own opinion of his own conduct, for the judgment of his conscience and the applause of his sense of right, respect for these things so far outweighs aught else that, if they be secure, he has no time and no need to think long of what beside he may lack.

In this connection you will be called to deal with a form of sophistry sufficiently harmful to merit a word of warning. You may be urged to say nothing about vicious and dangerous conditions lest the credit of the State or the city or your own political party may suffer by the disclosure. Believe me, young men, such counsel is cowardly or treacherous. To make a dwelling healthy you must clean it up, not hide its filth; you must let in God's sunlight, not shroud it in the gloom which fosters foulness; and to make your State or your city or the party you have chosen respected you must make that party, city or State worthy of respect from right-thinking men. If there be aught amiss in the community whereof you form a part, show up the evil before all men, and appeal to public opinion there or elsewhere, if need be to public opinion throughout our whole Union of free States, to arouse or shame the public servants or the voters who can set all this aright and who will not. And, my young friends, I can wish each one of you today no better wish than that, in the evening of his life, he may look back to this morning through years of work, of strife, perchance of sorrows, and in those years find nothing whereof, as he thus looks back, he shall then feel ashamed!

CO-ORDINATION OF DISCIPLINE IN MEDICAL TEACHING.—THE CLINICAL SEMINARY—ITS ACADEMIC ALTRUISM. A SYMPOSIUM ON NUTRITIONAL THERAPY.

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The duty of conscientious physicians and surgeons to keep abreast of the progress in the medical sciences does not meet with punctilious fulfilment in medical schools, where research is not a regular part of the curriculum.

There are only three methods of keeping step with the advancements of medical science:

1. Personal investigation and objective research in the laboratory or clinic, with exact recording of phenomena and data observed, preferably under the guidance of a man who has successfully completed similar research before and who is conversant with the instruments—apparatus—methods and points of inquiry, the difficulties to be avoided and the literature of the subject.

2. Seeking to learn by the experience of others, by attendance upon lectures and presentations given by men who are acknowledged to be thoroughly familiar with their special field of endeavor, reports of abstracts from articles in medical and scientific journals. Here is the proper field for a medical-journal club.

3. Conferences limited to the discussion of special topics and introduced by one or two persons who have prepared a scheme restricting the reports to a well-defined practical or scientific territory, so that diffusiveness and unnecessary expansion be avoided, and the mental energy be concentrated wherever possible upon one single and simple problem.

This is the proper function of a seminary in the sense as it is employed by German universities.

There should be regular annual reports by every teacher or instructor, presented in writing to the board of instruction, giving the subject-matter of what he teaches in form of synopsis, the hour of lecturing or conferences, the number of hours of laboratory work and the scientific territory covered.

By such a system the various members of the

board of instruction would keep informed concerning the manner and matter of didactic and laboratory discipline in other departments, but this would not necessarily bring them abreast of the progress of these other departments. For what often impresses a teacher as new and valuable in other special sciences is not in reality new, but has been ascertained long ago and which he has not had opportunity or failed to become familiar with.

It is a very frequent and a damaging defect in medical discipline that each teacher revolves almost exclusively in his own narrow little circle. To a certain extent this is unavoidable and perhaps even necessary, for specialization means concentration of energy on a restricted cultural domain.

If, however, specialization proceeds so far as to isolate the teacher from the other disciplines in medicine, he must unavoidably, although perhaps unconsciously, become an ineffective teacher, because his very specialization and isolation has not only estranged him to other branches of medicine, but has accustomed him to attribute an exaggerated importance to the small field he has succeeded in mastering (assuming that he has acquired a real mastership in it).

There is a very distressing lack of co-ordination of medical discipline not only in the University of Maryland, but in most all American universities, for men who are very capable in their own line of endeavor—clinical or purely scientific—confess a woeful ignorance concerning the fundamental facts of correlative branches of medical knowledge.

As the various component sciences of medicine grow and expand this discrepancy will become more and more evident, and even now it is a very serious problem of how to ameliorate it.

To my understanding the gaps between different co-ordinate branches cannot be obviated entirely, but much can be done to reduce the degree of individual separation.

One way is by way of a SEMINARY, in which such problems are discussed as bringing into play the minds of men trained in both the pure and applied sciences of which medicine is composed. Such a seminary needs the utmost academic loyalty on the part of the teachers of the University. A purely egotistical man, one who is content to revolve in his own narrow orbit, whose connection with the University is conditioned only

by the benefits that accrue to him personally, will not make a helpful seminarian, for in a clinical seminary the guiding principle is the "Golden Rule."

This year the problem of treatment by *dict or nutritional therapy* has been selected as the subject around which all teachers could exchange their thoughts in a most fruitful manner. These italicized subjects have already been discussed on Thursdays from 1 to 2:

1. *The Physics and Chemistry of the Various Foods.*
2. *Caloric Values—Isodynamic Equivalents.*
3. *The Physiology of Food.*
4. *Food in Its Relation to Domestic Economics.*
5. *The Pathologic Physiology of Food Effects.*
6. *Diet in Surgical Treatment, Pre- and Post-operative Feeding.*
7. *The Diet in Infancy and Adolescence.*
8. *Food Anaphylaxis and Idiosyncrasies.*
9. *The Techniques of Nutritional Therapy and the Dietetic Comfort.*
10. *Artificial Nutrition.*
  - (1) By stomach tube; (2) by rectum, the nutritive enema — composition — technique; (3) by the skin—subcutaneous nutrition.
11. *Dietetic Cures:*
  - Nutritional Therapy in—
    - (a) Pulmonary and Throat Diseases.
    - (b) Heart and Vascular Diseases.
    - (c) Nerve—Cord and Brain Diseases.
    - (d) Digestive Diseases — Stomach, Intestinal, Hepatic, Pancreatic, Splenie.
12. *The Nutritional Therapy in Diseases Caused by Parasites, Protozoa, Tapeworms, Ascaris lumbricoides, Oxyuris, Tricecphalus dispar, Uncinaria (or Ankylostoma duodenale), Trichina spiralis, Anguilla intestinalis.*
13. *Nutritional Therapy of Acute Infectious Fevers.*
  - The Pathologic Metabolism of Fever.
14. *Nutritional Therapy of Diseases of Metabolism:*
  - (1) Of Diabetes Mellitus.
  - Different Forms of Diabetes.
15. *Nutritional Therapy of Uric Acid and Diathesis, Gout, Arthritis Deformans, Oxaluria and Phosphaturia.*

16. *Nutrition Therapy of Anemia, Chlorosis, Leukemia, Pseudoleukemia, Basedow's Disease, Myxedema, Addison's Disease.*
17. *Nutritional Therapy of Skin Diseases.*
18. *Nutritional Therapy of Syphilis and Disturbances of the Sexual Functions.*
19. *Nutritional Therapy of Kidney Diseases.*
20. *Nutritional Therapy of Urinary Organs.*
21. *Nutritional Therapy of Gynecologic Disorders.*
22. *Nutritional Therapy of Obstetric Conditions.*
23. *The Pathologic Physiology of Fat Accumulation and Nutritional Therapy of Obesity.*
24. *Nutritional Therapy of the Abnormalities of the Mineral Metabolism; the Disturbances of the Calcium and Iron Metabolism.*

There are numerous instructors who are conspicuous by their absence at the regular medical gatherings, and who are never seen at the academic ceremonies, reunions of alumni, nor at meetings of the board of instruction.

In fact, it would hardly be known that they are connected with the University except for their attendance upon duties for which they are paid or upon functions from which they anticipate a direct or indirect personal advantage. These are the academic "drones," whose doubtful utility seems to be to serve as ballast in the ship of academic progress. But ballast in a ship is really useful for purposes of steadiness. The word "drone" has another meaning than that of an unprofitable sluggard; it also means that which gives out a "grave and monotonous dull sound."

And this is the one thing in which University drones excel. They do little work, but they are often ready to express "dull and monotonous sound" of criticism about those who are doing work and having their shoulders to the wheel.

Let those who are happy in their work not be discouraged by the drones, no matter in how dignified a tone they utter their fault-finding. Criticism is of benefit only when it is constructive, and unless accompanied by feasible recommendations for betterment it were wiser if all criticism were suppressed.

A clinical seminary is an organization of medical workers where the members are primarily actuated by academic altruism and love of culture.

The question, "What good will it do me?" is a secondary one, though personal advantage does

come from this kind of an association, because the various members are made conversant with domains of knowledge acquired by others, sometimes at the expense of life's long endeavor. Thereby they gain new insight not only into problems of life not studied by them, but new aspects of and new pleasures in their own scientific acquirements. The seminary meets weekly on Thursdays at 1 o'clock in the nurses' classroom of the University Hospital, and if those of the staff of instructors who will be interested will send their names to the author, they will be kept informed of the subjects under discussion.

#### INFANT-FEEDING.

*By Nathan Winslow, M.D.*

(Continued from November Bulletin.)

#### ARTIFICIAL FEEDING.

*Wet Nurse.*—In very many cases, try as you will to regulate quantity or quality, you will fail; then the milk of another woman is better, for it is the food most nearly adapted to the child's digestive organs. Moreover, her milk is practically sterile, and the proteids of her milk and that of cow's are different. If the baby to be wet-nursed be only a few days old, the child of the wet nurse should not be more than two months of age. If the child is a month old, it does not matter if the nurse has been nursing four months. The woman selected should be healthy and free of phthisis or syphilis. In order to ascertain if the last-mentioned diseases be present, examine the applicant's mouth and nose. By tapping on her sternum you will be enabled to discover latent syphilis. In case of doubtfulness, you should resort to an examination of the genitalia and breasts. Do not neglect to also subject the child of the nurse to a thorough examination, especially its anus and mouth. Any woman who is compelled to go out as a wet nurse is apt to be underfed. A woman who is half starved, when surfeited is very apt to have acute digestive disturbances, which will affect the child to be wet-nursed.

*Cow's Milk.*—If a wet nurse cannot be secured when mother goes dry, cow's milk is generally selected as the child's food, notwithstanding there are several animals whose milk is more like the human. Consequently, the method of its collection and handling, as well as the care of the animals, should be of the utmost importance to physicians.

No cow which is kept constantly indoors furnishes a milk suitable for infant consumption. In order to eliminate the likelihood of indigestion, it is better to feed the infant on the run of a dairy than on the milk of a single cow. Investigators have discovered that at least one-third of the cows furnishing milk to cities are contaminated with tuberculosis. The Jersey and the Alderney strains, noted for furnishing very rich milk, are more liable than the common cow to the "White Death." Therefore, we have had laws passed compelling owners to submit their stock to the tuberculin test, viz., the injection of 3 cc. of a 10 per cent. solution of Koch's tuberculin into their tissues. A rise of 2 or 3 degrees in the temperature after the inoculation indicates the presence of phthisis. If the test is positive, the cow should be promptly killed.

Cows must be protected from undue extremes of temperature. They should be in the air every day. As far as possible all the milking should be aseptic. The number of bacteria drawn by these precautions are less than one one-thousandth of those usually present. After the milk is drawn, cool it immediately, for a good nidus for all sorts of organisms is furnished if you neglect this precaution. The milk should be fresh; it should not be over 12 hours old. Before we accept the milk we should be sure the animals are healthy. Rigid cleanliness should be observed about the stable, in the animals themselves, in the milker, pails, cans, bottles, etc. We would be surprised at the amount of dirt removed from milk by separator. The food of the cattle should be fresh, and not brewer's grain. Milk should not be transported long distances, but should be bottled and sealed at the dairy and then kept at 45° temperature until received by the consumer. In this way we do away with unnecessary handling.

*Principles of Modification.*—The principles of preparation of an artificial diet are based upon the quantitative as well as qualitative difference between cow's and woman's milk. Therefore, it should be our aim to simulate the human variety as closely as possible. If we desire to change the ingredients to the same proportion as the secretion of the human breast, it is necessary for us to be familiar with the percentage composition of cow's milk. The following table gives the average composition and difference between cow's and woman's milk:

*Woman's Milk.*

Specific gravity, 1031.  
Reaction neutral or alkaline, never acid.

Percentage of water, 87-88.

Sterile.

Fats, 3-4 per cent.

Proteids, 1-2 per cent.

Sugar, 6-7 per cent.

Ash, 0.2 per cent.

Solids, 12.13 per cent.

*Cow's Milk.*

Specific gravity, 1032.  
Acid, never alkaline.

Percentage of water, 86-87.

Organisms present.

Fats, 4 per cent.

Proteids, 4 per cent.

Sugar, 4.5 per cent.

Ash, 0.7 per cent.

Solids, 13.14 per cent.

The color of cow's milk is white, whilst woman's is blue, the whiteness of the former being due to the calcium phosphate with which the casein is combined, and to the fats. The sugar, as in woman's milk, is lactose in complete solution. We find the greatest difference in the proteids; in cow's milk there are three times as much as in woman's. If acid is added to cow's milk, the coagulable part is four times as great as the non-coagulable, whilst in woman's the non-coagulable is twice as much as the coagulable. This phenomenon is due to the fact that in cow's milk there is more casein than lactalbumen, whilst in woman's milk there is less. In the stomach cow's milk coagulates into large firm masses, which dissolves slowly; woman's into loose, flocculent curds, which dissolve rapidly. It is this ingredient which gives us our chief concern in the modification of cow's milk, so reduce it to as low as 1 or 0.5 per cent. for a child during its first month of life, in order that the child's digestion shall not be disturbed. The proportion of proteids should be so low that they will not derange digestion; raise the percentage gradually. At the end of the first month the child is capable of digesting 1 per cent. proteid; fourth month, 1.5 per cent.; sixth month, 2 per cent. The proteids may be reduced by diluting ordinary milk with water. One dilution lowers the proportion of proteids to 2 per cent.; two, to 1.33 per cent.; three, to 1 per cent.; four, to 0.8 per cent. The inorganic salts are three times more frequent in cow's than in woman's milk. Remember that cow's milk is acid, so render it slightly alkaline by the addition of bicarbonate of soda or lime water—about grains xx of the former or one ounce of the latter to every 20 ounces of the solution. Destroy any organisms present by the application of heat, reduce the proteids at least one-half, add some

sugar, but decrease the fat slightly. The ash should be made to approximate the proportion in which it is present in woman's milk. The fat in human and cow's milk occurs in an emulsified form, and are identical, but in the case of the proteids we have an entirely different proposition to deal with; though the same chemically, they differ proportionally. In both the human and cow's milk the lactalbumen and casein are present, but in woman's milk there is twice as much lactalbumen as casein, while in cow's milk there is a reversal of this condition, casein being four times as abundant as lactalbumen. It is this condition of affairs which explains why human milk during digestion solidifies in soft flocculent masses and cow's in a solid curd, as casein predominates. It is this excess of casein which upsets the proteid digestion in the youngsters. In both cases sugar exists as lactose, is perfectly soluble and easily absorbed, but is more abundant in human milk; inasmuch as the calf obtains a portion of its carbohydrates from the grass it eats, so in modifying add sufficient sugar to bring up the proportion to 6 or 7 per cent. If this element is disregarded when modifying, the child will not be subject to indigestion, but will show a diminished body weight. When the necessity arises to institute artificial feeding, you should endeavor as nearly as possible to approximate mother's milk; the capacity of the stomach should be investigated; the formula, size and number of feedings for the 24 hours must be decided upon. It has been found the best practice to prepare the whole amount to be used in the 24 hours at one time, instead of newly preparing every feeding. The gastric capacity can be estimated fairly accurately by the aid of the formula, which calculates that the capacity of the stomach is equal to 1 per cent. of the weight of the body; for example, a child weighs 100 ounces at birth; therefore, its gastric capacity is, according to the formula, one ounce, but the formula further states that for every day of life during the early months one-thirtieth of an ounce should be added, so that at the end of the first month the capacity of the child's stomach should be two ounces. After the first three months the rate of increase of the capacity of the stomach is one-half an ounce a day.

During the first month the baby should be fed at least 10 times daily. At two weeks of age the gastric juice can digest fats, 2 per cent.; proteids, 0.5 per cent.; sugar, 6 per cent. Keep up the fat

percentage by diluting cream, *i. e.*, milk with excess of fat. The cream may be obtained from the milk either by skimming off the fat or by throwing it down with the centrifuge. If milk is allowed to stand in ice water for four or five hours, the cream which is skimmed off is called 8 per cent. cream; if at six hours, 12 per cent. cream is obtained; after eight hours, 16 per cent. cream. When the percentage of cream is spoken of the reference is to the amount of fat it contains. Bear in mind whatever the percentage of cream employed, there will be 4 per cent. protein present. Twelve per cent. cream can be secured by using equal parts of 20 per cent. cream and plain milk, or by the addition of two parts of 16 per cent. cream to one part of skimmed milk. By adding one part of 20 per cent. cream to three parts of plain milk, or one part of 16 per cent. cream to two parts of plain milk, an 8 per cent. cream is secured. It is one of these solutions which we usually modify to obtain the infant's food. Gravity cream has 16 per cent. fats, 4 per cent. proteins, 6 per cent. sugar; consequently, as stated above, the composition of cream differs from that of milk in only the fat percentage. If you dilute gravity cream eight times, the result will be a liquid with a 2 per cent. fat, 0.5 per cent. protein, 0.5 per cent. sugar composition. Such a formula is applicable to a healthy new-born child or to a sick infant of several months of age. When the child is a month old, the percentage composition of the milk should be, fats, 3 per cent.; proteins, 1 per cent.; sugar, 6 per cent. A milk of this percentage may be obtained by diluting a 12 per cent. cream four times with water. The rule is in a healthy child to begin with a 2 per cent. fat in early life; by the end of the first month increase this element to 3 per cent., and after five or six months to 4 per cent. For a healthy child one week of age we can use the following formula: F., 2 per cent.; P., 0.5 per cent.; S., 6 per cent. As there are 10 feedings a day during the first month, and the gastric capacity is only an ounce, 10 ounces of food daily will be necessary to satisfy the child's hunger, so dilute a 16 per cent. cream eight times by taking two ounces of cream and adding 14 ounces of water, or, better still, 13 ounces of water and one ounce of lime water. As the sugar is still below par, add a half ounce of sugar. This method gives us four ounces more than absolutely necessary, and it can be thrown away if not needed.

*Feeding of Children During the Second Year.*—At 12 months of age the child should get F., 4 per cent.; S., 5 per cent.; P., 3 per cent.; therefore, we order a mixture consisting of eight ounces of skimmed milk, four ounces of 16 per cent. cream, four ounces of water and two drachms of sugar. If desired, barley water may be substituted for a portion of the water, and we obtain a solution with the ingredients in the above-mentioned proportions. About the fifteenth or sixteenth month healthy stomachs are prepared to digest pure cow's milk, nevertheless, as in modified, before use sterilize in large cities. Through force of circumstances, in a few instances, the milk has to be modified throughout the entire second year. By this time it is proper to add starchy solutions as diluents to the milk. Barley water made by the addition of a teaspoonful of barley flour to 12 ounces of water cooked for 15 minutes answers the purpose excellently. In constipation oatmeal water should be given the preference over barley water as a diluent, but rice water may be substituted for either of these. When milk is diluted with a farinaceous substance, not so much lactose should be added. Toward the end of the second year the diet may be made a little more liberal and varied by the addition of a little bread, preferably stale. After the teeth have fully erupted it will not be amiss to add a little scraped beef or an egg to the diet. Fruit in season are not absolutely prohibited. Indigestion, a not infrequent affection of this period, is often traceable to the error so frequently committed of permitting the too early ingestion of solid food. It is well to keep the proteins between 3 and 3.5 per cent. for the first half of the second year. Constipation can usually be avoided if the fat proportion is not reduced below 4 per cent. During the first half of the second year the child requires 40 to 50 fluid ounces of food daily; second half, 55 ounces daily, which can be given in four or five feedings. At two years of age we give the thicker foods, such as jellies, oatmeal flavored with sugar and cream, rice, well-done roasted potato seasoned with butter, pepper and salt, and a baked apple or well-stewed prunes. For a child 24 months of age a fair daily dietary would be somewhat as follows: Breakfast, bread and milk; 10 A. M., milk and potato; dinner, milk, beef juice or finely-scraped beef, and a soft-boiled egg; afternoon, bread, milk and a little orange juice; supper, bread and milk. (To be Continued.)

# THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, MD., DECEMBER 15, 1910.

## THE ALUMNI COUNCIL.

At the annual meeting of the General Alumni Association, held in Davidge Hall November 11, 1910, the Committee on Alumni Council, through its chairman, Dr. R. Merrill Hopkinson, submitted to the association for approval the tentative plan for the organization of such a body and which the Board of Regents had previously ratified. This concession on the part of the Regents is to be greatly commended, and should indicate to the carpers that the management of the University is not entirely selfish, but is wide awake to the needs of the University. Things have not been at a standstill at the old University, as many would have us believe, but moving along slowly but surely. Nearly every day there are indications of progress. We have just been awakened to the possibilities of what is before the institution, and in the not very distant future we will realize some bright day that our school is a factor in the educational world. Times have changed and so has the University of Maryland.

Believing that the sooner the inauguration of the Council is under way the better, the board of directors of the General Alumni Association and the Executive Committee have decided to call a mass-meeting of the alumni Wednesday, January 11, 1911, at 8.15 P. M., in Davidge Hall, corner Lombard and Greene streets, for the purpose of selecting the Committee on Nomination. Every alumnus, be he a member of the association or not, is entitled to attend this meeting and vote, but if he desires to have a say as to whom shall represent him on the Alumni Council, he must join the General Alumni Association, of which

the dues are \$1 yearly, as only members of this association are entitled to a vote. Fellow-alumni, this is our golden opportunity to show our interest in the welfare of our Alma Mater. For years we have been appealing to the Regents to give us a voice in the management of the institution. They have at last consented. Now is our opportunity to show whether we were in earnest or were only seeking an occasion to maliciously impugn the motives of those in control.

The tentative plan, which is as follows, was unanimously adopted by the General Alumni Association:

## TENTATIVE PLAN FOR ORGANIZATION SUBMITTED TO, AND ACCEPTED BY, THE REGENTS OF THE UNIVERSITY OF MARYLAND FOR AN ALUMNI COUNCIL OF THE UNIVERSITY OF MARYLAND.

To consist of 20 graduates of the University, elected by the alumni, and the president of the Alumni Association *ex-officio*. Of the elective members, four shall hold the degree of A.B., B.S., A.M. or M.S., representing St. John's College; four the degree of M.D., four the degree of Phar.D. or Phar.G., four the degree of D.D.S., and four holding the degree of LL.B. They must have held their degree for 10 years or more. Graduates having more than one degree from the University may be elected in either group. Not more than 12 shall be residents of Baltimore city or county, and no Regents shall be eligible.

Members are to serve four years, and five are to be elected yearly, one from each group. They are eligible for re-election, with the proviso that at least one new member shall be elected each year.

In order to put the plan in operation for the first year, it is proposed that a mass-meeting of the alumni, to be held on the 11th day of January, 1911, shall authorize the selection, by its chairman, of a committee on nomination, to consist of himself and five other alumni, of whom at least one shall hold the degree of M.D., one the degree of Phar.D. or Phar.G., one the degree of LL.B., one the degree of A.B., A.M., B.S. or M.S., and one the degree of D.D.S. This committee, after receiving suggestions from the branch Alumni Associations wherever organized, shall select from the whole body of alumni eligible for membership in said Council the names of 25 men, and shall, on or before —— mail to every alumnus a ballot containing said 25 names, with such infor-

mation as to residence, occupation, degree and attainments as may seem proper, and with full directions as to voting upon the same, and furthermore the necessity for the payment of an enrollment fee of \$1, which entitles him to a vote and to membership in the General Alumni Association for one year. Members of the General Alumni Association in good standing shall not be required to pay an enrollment fee.

Each alumnus shall vote for 20 out of the 25 names, following the proportion of the various degrees indicated above, namely, four A.B.'s, A.M.'s, B.S.'s or M.S.'s, four Phar.D.'s or Phar.G.'s, four M.D.'s, four LL.B.'s and four D.D.S.'s, and shall return his ballot to the committee on or before ——. Upon this latter date the committee shall meet and count the ballots cast, and shall declare the four men receiving the highest number of votes in the five groups, respectively, to be elected to the Council. The 20 alumni so elected, with the president of the Alumni Association *ex-officio*, shall constitute the Alumni Council.

At the first meeting of the Council in —— the members of each group shall determine by lot which are to serve for one year, or for two, three or four years, respectively.

On or before —— it shall submit to the alumni rules for the nomination and election of subsequent members, so that an election may be held upon the —— of —— and of each succeeding year.

The Council shall elect a chairman and a secretary from among its members to serve for one year, who shall be eligible for re-election. Vacancies occurring by death or resignation may be filled temporarily by the Council, such appointments expiring at the following annual meeting.

The Alumni Council shall hold two meetings annually, the first on ——, the second six months thereafter, and as many more meetings as the chairman may consider necessary; provided, also, that he shall be obliged to call a special meeting at any time upon the written request of seven members. Seven members shall constitute a quorum for the transaction of business. At the two meetings of the Council a report shall be requested from the provost and treasurer of the University, setting forth the general and financial condition of each department, any new buildings planned, any vacancies existing or prospective in any of the teaching departments. They shall also

state the condition of the halls, libraries, laboratories, clinics, hospitals, etc. The Council shall adopt such constitution or by-laws as it may deem advisable.

Through the chairman, the Council shall make suggestions and recommendations to the Regents upon any subject which it feels may benefit the University. It shall maintain an index of all former students and keep them informed of matters of interest to the University, impress its needs upon them and suggest means of providing for them. It may appoint committees to inspect and report upon the needs of the various departments of the University, to advance its material interests, and to take such other work as may seem advisable to it or to the Board of Regents.

In the filling of vacancies in professorships the Alumni Council requests to be empowered with the right of approval in a certain ratio of votes to be agreed upon between the Regents and the Council. For example, one vote of a Regent shall be counted as equal to two, three or four of the votes of the Alumni Council.

If the rôle of the Alumni Council shall not be purely suggestive, it is recommended that the Honorable Board of Regents invest this body with some limited degree of authority, in return for which they declare themselves willing to fulfil any duties the Regents may see fit to assign—e. g., administration, clerical, testing the financial condition, etc.

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In order that each and every one of us may be in a position to exactly appreciate the views of the Regents in this matter, the reply of that body to the Committee on Alumni Council is herewith appended:

*"Resolved,* That the secretary be, and he is hereby, instructed to report to the Committee of Ten of the General Alumni Association that the Regents have carefully considered their recent communication proposing the election by the alumni of five representatives of the alumni, none of whom shall be full professors, as additional members of the Board of Regents, and that, upon an examination of the charter, the Regents find no warrant for such an addition to their members, nor are the Regents inclined to recommend to the General Assembly an amendment to the charter authorizing this proposed change in the organization of the Board of Regents.

*"Resolved, further,* That the Regents approve

the election by the alumni of an Advisory Council, empowered to present from time to time to the Regents their views and wishes, and assure the Association of the Alumni that the Regents will gladly welcome and always carefully consider suggestions and recommendations emanating from such Advisory Council.

*"Resolved, also,* That the secretary report further to the Alumni Association that their suggestion with reference to the payment of a salary to our provost is now under consideration by the Regents, and shall be acted upon at an early date; and, further, that the Regents see no reason for a reorganization of the University by 'the creation of a governing body of trustees independent of the teaching bodies,' and are, consequently opposed to an amendment of the charter of the University in order to accomplish this suggested reorganization.

"JOHN PRENTISS POE,  
"HENRY D. HARLAN,  
"R. DORSEY COALE,  
"THOMAS A. ASHBY,  
"JOHN C. HEMMETER,  
"Committee.

"May 26, 1909."

Although THE BULLETIN speaks entirely unofficially, it is decidedly of the opinion that the Board of Regents, or at least some of its members, are veering to the conclusions that the labor of teaching alone is sufficient to engross their entire attention, and that it will only be a matter of time before the government of the financial affairs of the University will be turned over to an independent board of control.

## ITEMS

The following address was delivered on Academic Day by William L. Marbury:

"I have been invited by the Committee of Deans of the University of Maryland to say something upon this occasion in memoria of Major Venable.

"As his one-time pupil, it affords me unfeigned pleasure to have this opportunity to give some expression to the feeling of admiration and affection which we all had for him.

"At the same time I am bound to confess that, in undertaking to say anything with reference to Major Venable upon such an occasion, I feel a very considerable diffidence.

"In speaking of one whom we admired and loved it is so easy to fall into the set phrase of indiscriminating eulogy—commonplace praise—and Major Venable, of all men, ought not to be subject to such posthumous punishment, himself having been guilty of perhaps as few commonplace utterances during his stay on earth as will be credited to any of our acquaintances.

"What I shall have to say, therefore, must needs be brief, so that it may, at any rate, be as little tedious as may be. Major Venable himself was never tedious, no matter what subject he might be talking about or how long he might talk about it. Yet there are some things which must be said, if anything is said, in order that justice at least may be done.

"In some sense the best work of Major Venable's whole life was done in the service of the University of Maryland, and it would seem, therefore, eminently fitting that we, as the representatives of that University, should make some record of our appreciation of that service and our esteem of the man who rendered it.

"Major Venable's life as a whole presents a fine record of the able and faithful performance of every private and public duty of the citizen. If his whole story were told in any detail, it would make a very interesting book. I will make no attempt to do more than mention briefly the salient features of his career.

"He was born on February 18, 1839, in Charlotte county, Virginia, and was educated at Hampton-Sidney College, from which he graduated in 1857, and at the University of Virginia, where he was engaged in the study of applied mathematics and civil engineering when his studies were interrupted by the breaking out of the Civil War.

"What Major Venable's opinion may have been with reference to the question of the right of secession and the other issues which were more or less directly involved in that war I do not know; I never heard him say. I never asked him, nor do I regard it of importance. The strongest, the most earnest and insistent opponents of secession were to be found in Virginia just prior to the breaking out of the war. Not a few of those who subsequently became leaders of the Confederate armies denied that any such right existed, or at any rate greatly doubted its existence. When, as a matter of fact, however, war came, these men, acting upon the instinct which constitutes the real

basis of all patriotism, stood with their own people, and young Venable stood with them. On April 21, 1861, he enlisted as a private in the Richmond Howitzers, and served in the Confederate Army until the close of the war, at which time he had been promoted to the rank of major of artillery and engineers. He stood that great trial of four years to the end, and stood it so well that after the war was over he was thought fit to be associated with Robert Lee as one of the faculty of Washington and Lee University at Lexington. I am of those who believe that nothing finer can be said of any man than that he did such a thing.

"Major Venable began the practice of his profession in Baltimore in 1871, where he entered into partnership with Mr. Joseph Packard—a partnership which continued, under the name of Venable & Packard, until 1892. In 1900 he formed, with two young lawyers, the firm of Venable, Baetjer & Howard, of which he continued to be the senior member until his death.

"That Major Venable was a lawyer of a very high order none who knew him will deny. His reading in the law was most varied; his learning immense. His knowledge of the principles, the history, the philosophy of the law was perhaps greater than any man of the time at the bar. Many men of great learning and great knowledge of the law have not been successful; such was not the case of Major Venable. When he died he had been for many, many years one of the most successful practitioners at the Maryland bar. Starting with nothing, he had succeeded at an unusually early age in making himself financially comfortable, and, notwithstanding his many acts of generosity, was able to leave what, for a lawyer, might be considered a considerable estate.

"But, as I have already intimated, Major Venable's finest work was done in the service of the University of Maryland.

"He became a member of the law faculty in 1872, and continued during the greater part of that period to lecture to successive classes upon the topics assigned to him. These topics were principally real estate, leasehold estate, constitutional and statutory law, jurisprudence, and, for a time, criminal law and the law of torts.

"The flight of years has been all too swift—some eight and twenty of them have made the circle—since the year during which I attended

those lectures, and I have never heard his equal as a teacher.

"His success in that respect was by no means due entirely to his learning, great and varied though that was. Nor yet altogether to his capacity for clear and lucid statement and illustration, great as his gifts were in that respect; but rather, in at least equal degree, to his extraordinary personality.

"I should say that the distinctive feature of Major Venable's character was his exceeding interestingness. He was never dull, never commonplace; he had no banalities of thought or of expression. However ordinary the topic which he was discussing, he never failed to present it from some point of view which was interesting, if not—as was generally the case—original. His mind was essentially philosophical, and he never failed to discover and expose the philosophic aspect of the matter in hand. It has been observed by the greatest dramatists that

"There is ever some quality of goodness in things evil,

Would men observingly distill it out;  
and so it may be said that no subject is so dry, so commonplace, but that some view of it exists which would be interesting if the mind of him who seeks to speak of it be only shrewd enough to see that side.

"Major Venable had the kind of mind which never failed to discharge that function. He saw every subject through an interesting viewpoint, and showed it to his auditors from that point of view. As a natural consequence, his lectures were always interesting. I have the vividest recollection of his lectures on the law of real estate. It may be said of him with literal truth that he touched no subject which he did not make interesting, and under his magic treatment the dullest, aridest, dreariest waste of all the law's domain was made to blossom as the rose. The 'Rule in Shelley's Case' became a boon companion; the 'Statute of Uses' a well-beloved friend; the 'Rule Against Perpetuities' a veritable sweetheart to the aspiring youth of the Law School of the University of Maryland. There is no way to exaggerate the success which Major Venable met with in his efforts to make the law a real, living thing in the minds of the students and to arouse their keenest interest in its study. It would be difficult to overestimate the value of the service which he thus rendered to the young men, students of the pro-

fession, in this city. His service to the University can certainly never be repaid. His humor and sympathy with young men were inexhaustible.

"It is not our province here to discuss at any length the services which Major Venable rendered to the public at large; they were many and great. He never failed to bear his full share of the burdens of citizenship. Without having ever manifested the slightest inclination for a political career, he nevertheless belonged to a race of men who had been accustomed to have something to say with reference to the laws under which they should live and the men who should administer those laws, and Major Venable on all proper occasions was ever ready and able to say what had to be said boldly and effectively. The immense labors which he performed in working out a system of parks for the city of Baltimore are not fully known or realized by the people who will benefit thereby. They illustrate, however, the intensity of his public spirit.

"He was a man of very broad and generous sympathies, a genuine lover of his fellow-man. Those of us who did not always agree with his political theories loved him none the less on that account, recognizing, as we did, the generosity of his motives and the unfailing sincerity of his purposes.

"Major Venable rendered a great service to his profession by demonstrating by his life that a man may have wide and intellectual interests and take and have an active interest in public affairs without in the least impairing, but rather thereby increasing his effectiveness as a practicing lawyer. Many of our profession seem to fear to take the part which they should take in public affairs lest they be suspected of neglecting their profession. Major Venable never yielded to such fear, and his eminent success in his profession serves to illustrate their groundlessness.

"But for the infinite variety of his intellectual interests, his love of literature and his wonderful companionability the closing years of Major Venable's life might have been lonely. As it was, few men in our day have passed and left so many loving friends behind, so many who with unfeigned grief could say, 'Peace to his ashes!'"

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Dr. Randolph Winslow has sent to the Trustees of the Endowment Fund the following communication, dated October 27:

"I have hitherto contributed \$1125 to the En-

dowment Fund of the University of Maryland without condition, except that it should be used for the benefit of the Medical School. I now beg to submit the following proposition:

"1. That the \$1125, principal and interest, to the extent of \$75 be set aside, making \$1200.

"2. I hereby agree to contribute an additional sum of \$1300, making a fund of \$2500, to be devoted to a *scholarship* for the benefit of worthy students of medicine, under such conditions as will be prescribed upon the acceptance of this offer.

"3. I agree to complete this arrangement by turning over to the Trustees 5 per cent. bonds of the University of Maryland to the amount specified within three years.

"4. The scholarship shall be known as the Randolph Winslow Scholarship."

Dr. Winslow's generous offer was accepted by the Board at a special meeting held November 9.

The following are the conditions of the gift:

"The candidate shall be nominated by the Faculty of Physic.

"He shall be a needy student of the senior, junior or sophomore classes of the Medical School.

"He must have maintained an average grade of 85 per cent. in all his work up to the time of awarding the scholarship.

"He must be a person of good character and must satisfy the Faculty of Physic that he is worthy of and in need of assistance.

"The interest only shall be applied to the above purposes."

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A canvass for endowment is in progress. The plan adopted embraces the entire State, and an appeal will be made to all Marylanders. A chairman alumnus has been appointed in each county, and requested to confer with his fellow-alumni and enlist their interest and co-operation. He is expected to send a list of prominent citizens of his county to whom the printed appeal can be mailed, and who shall be called upon later as far as possible by the committees. A city committee of 100 has been appointed to canvass the city. One thousand copies of the "appeal," signed by the Committee on Endowment, are being sent out, each accompanied by a blank subscription. It only remains now for the *workers* to do their part—to call upon the citizens as far as they are able, to present the claims and needs of the University

and earnestly to solicit their contributions. This personal solicitation is, as we have already said, of the utmost importance. Without it we can accomplish little, and even with it we shall have to use our utmost effort to secure the results at which we aim.

We urge upon all who have been called on to take part in this great undertaking, this supreme effort to secure urgently needed help for the University, to place it for all time to come upon a safe, a sure, a lasting basis. We trust that no one will refuse to give a liberal portion of his time and effort to this good cause. The following is the circular-appeal referred to:

UNIVERSITY OF MARYLAND,

Baltimore, October 20, 1910.

*To the Citizens of Maryland:*

On behalf of the University of Maryland an earnest and urgent appeal is made to you to give your aid and encouragement to this well-known institution by contribution or subscription to the Endowment Fund of the University. It is hoped and believed that this will commend itself alike to your judgment and generosity. Some of the reasons for this confidence are:

1. The University has been in existence now for more than a century, located in the chief city of our State, and during that period has been well and favorably known in both our own and other States.

2. Its various departments have trained and sent forth some of the most eminent scientific, professional and scholarly men of our nation, thus attesting the efficiency of the instruction.

3. It is a *University* in the true sense of that term, providing for its students academic, scientific and professional departments.

4. The citizens of Maryland and natives of this State have in times past been generous in their response to appeals in behalf of education and taken a just pride in the institutions of this State. Their gifts have been freely bestowed both at and away from home, but this University has shared but slightly in this generosity.

5. There is a great present need of funds by this University in the way of an endowment, that the instruction and opportunities afforded for education here shall not fall below those given in other institutions lavishly endowed, in large measure by the private generosity of our own citizens.

6. What is needed is an endowment, whereby the future of the University shall be assured.

#### WHAT HAS BEEN DONE.

Contributions, largely from our own alumni, aggregating nearly \$30,000, have been received, some for a general endowment, some for scholarships, and some for special objects, all of which have been safely invested, not by the Regents, but by a corporation of alumni of the University specially chartered for that purpose. Not one dollar of the principal of these funds, but the income alone, is available for the purposes indicated by the donors.

#### HOW YOU CAN GIVE.

By a direct, present gift or by a legacy in a will to the "Trustees of the Endowment Fund of the University of Maryland." The income can be applied as you may direct, either to (1) the general fund or purposes of the University; or (2) to providing a professorship or a scholarship in such department of the University, and subject to such conditions as you may direct; or (3) to such special object or purpose as you may wish.

Shall not the University of Maryland have a share in your generosity? Checks may be made payable to J. Harry Tregoe, treasurer, 300 North Charles street.

EUGENE F. CORDELL, *Chairman*;  
HENRY STOCKBRIDGE,  
JOHN B. CASPARI, JR.,  
CLYDE V. MATTHEWS,  
L. B. KEENE CLAGGETT,  
J. HARRY TREGOE,  
Committee on Endowment, University  
of Maryland.

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At the recent meeting of the General Alumni Association of the University of Maryland the following officers were elected for the ensuing year: President, Walter J. Dawkins; first vice-president, Dr. Charles R. Sadtler, class of 1873; second vice-president, James W. Bowers, Jr.; third vice-president, Isaac H. Davis; fourth vice-president, John F. Hancock; recording secretary, John Henry Skeen; corresponding secretary, Nathan Winslow, class of 1901, and treasurer, Daniel Base.

The Alumni Association adopted a tentative plan, submitted and accepted by the Board of Regents of the University of Maryland, for an Alumni Council. It will consist of 20 members, who are graduates of the University, elected by the Alumni Association ex-officio. Of the elect-

ive members, four shall hold the degree of A.B., B.S., A.M. or M.S., representing St. John's College; four shall hold the degree of M.D. of the Maryland University; four the degree of Ph.D. or Ph.G.; four the degree of D.D.S., and four the degree of LL.B. Each must have had the degree for 10 years or more. Graduates having more than one degree from the University may be elected in either group, and not more than 12 shall be residents of Baltimore or Baltimore county. A mass-meeting of the alumni will be held at the call of the president to authorize the selection of the members of the new Council. The purpose of the Council will be to make suggestions and recommendations to the Board of Regents, to appoint committees, to inspect and report upon the needs of the various departments of the institution. Vacancies in the professorships will also be approved by the Council by a certain ratio of vote to be agreed upon by the Board of Regents and the Council.

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Drs. Randolph Winslow, class of 1873, and John Mason Hundley, class of 1882, are attending the meeting of the Southern Surgical and Gynecological Association at Nashville, Tenn.

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Dr. Charles Franklin Strosnider, class of 1909, of North Carolina, and formerly a resident physician at the James Walker Memorial Hospital at Wilmington, N. C., is serving on the North Carolina Hookworm Commission, and is engaged in popular lectures throughout the State.

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Dr. T. Marshall West, class of 1909, of Fayetteville, N. C., is a visitor in Baltimore.

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Dr. Harry Arthur Cantwell, class of 1906, of Northeast, Md., was a recent visitor to the University Hospital.

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Mr. George Y. Massenburg, senior medical student, who has been confined to the University Hospital, has so far recovered as to be able to go to his home in Towson, Md.

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Dr. Norman S. Dudley, class of 1901, of Church Hill, Md., was a recent visitor to the University Hospital.

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The Louis McLane Tiffany Chapter of the Chi Zeta Chi Medical Fraternity of the University of

Maryland has leased a furnished house at 121 North Carrollton avenue. It has 25 members.

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Dr. Henry H. Weinberger, class of 1908, formerly of New York, has removed to Baltimore.

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Dr. Vernon Lee Norwood, class of 1885, has lately purchased a handsome cottage at Windsor Hills, Md., and will shortly remove there.

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Dr. Caleb Noble Athey, class of 1894, will erect a three-story addition to the dwelling on the southwest corner of Patterson Park avenue and Lombard street, Baltimore, to cost about \$9000.

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Speaking of the recent magnificent gift of the Ferguson estate, Radnor Park, made to the Hospital for the Relief of Crippled and Deformed Children by Mr. James Lawrence Kernan, the veteran theatrical promoter and hotel builder, Dr. Tunstall Taylor, the superintendent in charge, said:

"This gift and endowment will provide the little sufferers with one of the most complete and magnificent hospitals of its kind in America or abroad. With its beautiful parklike location in the suburbs, it is in keeping with the most advanced medical thought, as the patients are removed from the city's noises and contaminated air. The 'fresh-air treatment' is generally recognized as a most important factor in many acute and convalescent cases in promoting cure."

"We are going to keep the present location of the hospital, at Charles and 20th streets, as a reception place for cases, with accident and dispensary departments, gymnasium, brace and shoe shops, etc., and we will be enabled to keep in close, actual touch with the main group of buildings at Radnor Park by automobile service. Thus Baltimore will have one of the most wonderfully endowed institutions in the world, where infantile paralysis and other diseases peculiar to childhood may be treated, but where, furthermore, such diseases may be thoroughly investigated and research work, which has always been an important feature of this institution, will be much amplified."

"Each year valuable papers have been contributed in the past to medical literature by its staff, and many of the original methods here employed are to be found in the best German, French and English textbooks, through which this institution already has attained both a national and an inter-

national reputation. Such men as Dr. Adolf Lorenz of Vienna, the celebrated specialist on congenital hip dislocation; the late Dr. Albert Hoffa of Berlin, an authority on hip troubles and paralysis, and recently Dr. Fritz Lange of Munich were guests of this hospital and studied its methods.

"As a recognition of the excellence of the work of this institution, at the International Congress on Tuberculosis, held in Washington in 1908, many of the little patients here having tuberculosis of the spine and joints, honorable mention by special award was accorded this work for its value educationally.

"Recalling the past 15 years' work of this hospital, much credit is due to the Orthopedic Guild and the Orthopedic Auxiliary, which were organized on December 11, 1895. These ladies, in addition to providing much hospital linen, children's clothes and endowing beds, etc., bought in 1897 the Mountain Hospital at Blue Ridge Summit, Washington county, Maryland, as an adjunct, and have rendered it a most up-to-date and valuable addition for the climatic treatment of bone tuberculosis, this marking the first institution especially devoting a branch to the fresh-air treatment in a high altitude of surgical tuberculosis, in which it has been found as beneficial as in pulmonary tuberculosis."

Among the present hospital staff are Drs. Robert Tunstall Taylor, clinical professor of orthopedic surgery in the University of Maryland, surgeon-in-chief and superintendent; Henry Watters Kennard, class of 1899, and Howard Elmer Ashbury, class of 1903, assistant surgeons; A. Duval Atkinson, class of 1894, attending physician; Francis Miles Chisolm, class of 1889, attending oculist; John R. Winslow, class of 1888, attending laryngologist; Richard H. Johnston, class of 1894, attending aurist; Louis McL. Tiffany, class of 1868, and Randolph Winslow, class of 1873, consulting surgeons; Charles Wellman Mitchell, class of 1881, attending physician, and Hiram Woods, class of 1882, consulting oculist.

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Dr. Thomas J. Murray, class of 1910, is located at St. Mary's Hospital, St. Mark's avenue, Brooklyn, N. Y.

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At the annual meeting of the Baltimore City Medical Society Dr. Arthur Marriott Shipley, class of 1902, was elected president; Dr. Ridgeley Brown Warfield, class of 1884, vice-president;

Dr. Charles Willis Larned, class of 1893, censor, and Dr. A. C. Harrison, class of 1887, delegate to the annual meeting of the Medical and Chirurgical Faculty. Dr. Charles O'Donovan, class of 1881, read a paper before the meeting on "What Is Baltimore Doing for Her Water Supply?"

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In a recent letter to the University Dr. Michel S. Hanna, class of 1910, writes: "I receive THE BULLETIN regularly, and am so much interested in it. The medical and surgical articles, etc., it publishes are excellent, and I find much benefit in reading them. Other than that, THE BULLETIN keeps me in close contact with our Alma Mater. I enjoy knowing every new thing about the school, hospital and the alumni, more in particular the chaps of 1910. I understand that many of them have made a noted career in medicine and also in the matrimonial business, such as our married brethren Anderton and Mac, whom I congratulate. They are certainly brave to invade the fair sex before most of their classmates. In this connection I propose a meeting of our class to be held in Baltimore in 1935. Everybody should be present, together with his wife; the bachelors are excluded."

"We are now enjoying a fancy weather in this fancy land of the pyramids. The climate is certainly enjoyable, and American tourists have just begun to pour in by hundreds.

"Of the afflictions most annoying and prevalent in this country I mention chronic dysentery of different forms, belharzia, trachoma and hepatic troubles. Later I may send you a good résumé on some of these troubles.

"Hoping all our professors and teachers are well, I send them my best regards, and later am going to write them in length, beginning with Professor Winslow.

"Kindly accept my sincere compliments."

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Dr. Ira Burns, class of 1905, formerly of Oil City, Pa., is located with the Pennsylvania Railroad Relief Department, Wilmington, Del.

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Dr. Arthur Blake Clarke, class of 1906, of Plantersville, S. C., was operated on for appendicitis by Dr. Robert Catheart at the Infirmary, Charleston, S. C., November 18. We are glad to report that Dr. Clarke is doing well.

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The medical department at Bayview Asylum

has undergone a complete reorganization. Dr. Arthur Marriott Shipley, class of 1902, has been appointed surgeon-in-chief; Dr. Harry Dorsey Purdum, class of 1902, physician-in-chief to the Hospital for the Insane, and Dr. Gordon Wilson, physician-in-chief to the tubercular department. Dr. Wilson is associate professor of practice of medicine in the University of Maryland.

Dr. Arthur Marriott Shipley is a native of Anne Arundel county, Maryland, and was educated in private and public schools until 1898, when he matriculated at the University of Maryland, graduating in 1902 with the highest class honors. He was for two years assistant resident surgeon of the University of Maryland, and from 1904 to 1908 he served there as superintendent. He now fills the chair of therapeutics and surgical pathology in the University of Maryland. Dr. Shipley married, May 6, 1908, Miss Julia Armistead Joynes of Baltimore.

Dr. Harry Purdum Dorsey is a native of Frederick county, Maryland, and received his primary education in the public schools there and his collegiate training in Winchester, Va., afterwards entering the University of Maryland, graduating in 1903. He served as chief resident physician at Bayview for three years, then went to the Northern Michigan Insane Hospital, remaining there four years as assistant physician, and returning a few months since to Bayview.

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Dr. George D. Anawati, class of 1900, is located on Ramleh-Bacos street, Alexandria, Egypt.

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The Adjunct Faculty of the University of Maryland has tendered a gift of money for the purchase of additional books for the University's library, which now contains over 10,500 volumes and 6000 pamphlets.

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Miss Vera Wright, University Hospital Training School for Nurses, class of 1909, has been elected superintendent of the Emergency Hospital, Easton, to succeed Miss Annie Chapman, resigned.

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Dr. Lewis Mines Allen of Winchester, Va., was a recent visitor to the University Hospital.

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Dr. William Kelso White, class of 1902, and Mrs. White are receiving congratulations on the birth of a son.

## MARRIAGES

Dr. John Lindsey Messmore, class of 1909, of Masontown, Pa., was married on October 5, 1910, to Miss M. Gene Townsend, at Fayette City, Pa. Dr. and Mrs. Messmore will live at Masontown.

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Dr. Cyril Fowble, class of 1910, of Sparrows Point, Md., and Miss Geneive E. Isaacs, daughter of Mr. Marion Isaacs of Howard county, Maryland, surprised their many friends by going to Ellicott City December 12, 1910, and being married there. The ceremony was performed by Rev. Vernon M. Ridgeley in the parsonage of Emory Methodist Episcopal Church. Miss Mary Isaacs, sister of the bride, was maid of honor, and Mr. Alexander Isaacs, the bride's brother, was best man. Miss Isaacs entered Bayview as a nurse August 1, 1910. Dr. Fowble was a member of the medical staff there, and the affair developed rapidly into the romance which had its happy culmination at Ellicott City. Dr. Fowble is a graduate of Dickinson College, class of 1901.

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Dr. Russell Wesley Raynor, class of 1908, of Vienna, Md., was married November 16, 1910, to Miss Lola E. Wilson of Deal's Island. Miss Wilson is the daughter of Mr. and Mrs. Edgerton G. Wilson.

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Dr. Joel Whittaker, class of 1900, of Raleigh, N. C., was married to Miss Melissa Myers, daughter of Chief Justice Myers of Indiana, at Logansport, Ind., November 22, 1910.

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Dr. Harry Young Righton, class of 1907, was married to Miss Bertie Van Keuren, daughter of Mr. and Mrs. Ralph Van Keuren, at the First Baptist Church, Savannah, Ga., on Wednesday, November 30, 1910. Dr. and Mrs. Righton will live in Savannah, where Dr. Righton has built up an extensive practice.

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Dr. Granville Hampton Richards, class of 1908, of Port Deposit, Md., was married to Miss Mary Emma Wright, University Hospital Training School for Nurses, class of 1908, daughter of Mr. and Mrs. Millard Wright of Calvary, Md., in Baltimore on November 16, 1910. The ceremony was performed by Rev. R. A. Castleman of Balti-

more. The couple spent their honeymoon in Florida, and are now residing at Port Deposit.

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Dr. Joseph Lane Finley, class of 1884, of Kent county, Maryland, was married to Mrs. Emma R. Baughman of Baltimore, Md., at Baltimore, November 23, 1910. The ceremony was performed by Rev. E. C. Makosky, and took place at the home of Miss Harriet Musselman, 1113 Harlem avenue.

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The wedding of Miss Jean Parry Winslow, daughter of Dr. Randolph Winslow, class of 1873, to Mr. Herbert Fuller Carroll of Charleston, S. C., took place at 7 o'clock November 23, 1910, at Memorial Protestant Episcopal Church, the ceremony being performed by Rev. William Page Dame.

The bride entered with her father, by whom she was given in marriage, and was met at the altar by the groom and his best man, Mr. Clifford Carroll of Baltimore. She wore a gown of white crepe meteor embroidered in pearls, a tulle veil with orange blossoms, and carried lilies of the valley and bride roses.

Miss Mary Fayssoux Winslow, sister of the bride, was maid of honor. She wore pale blue satin, veiled in blue and silver, and carried white chrysanthemums.

The bridesmaids, Misses Eliza Leiper Winslow, Elizabeth Abbott of Moorestown, N. J.; Mary Elkington of Media, Pa., and Florence Wiss of Newark, N. J., wore gowns of apricot satin, veiled in chiffon and trimmed with crystals, and carried yellow chrysanthemums.

Little Miss Allen Carroll, niece of the groom, was flower girl. She wore a white frock with yellow ribbons, and carried a basket of yellow daisies. Randolph Winslow, Jr., the bride's nephew, was ring bearer.

The ushers were Dr. Fitz-Randolph Winslow and Mr. Caleb Winslow, brothers of the bride, and Messrs. Nathaniel Page of Berryville, Va.; Carroll Weatherly, Edgar Wagner, Robert Clift, Carey Bailey, all of Baltimore, and William Davidson of Chester, S. C.

A reception followed at the home of the bride, 1900 Mount Royal terrace, where the decorations were palms and yellow erysantheumns. Later Mr. and Mrs. Carroll left for their wedding trip and their future home in Charleston.

## DEATHS

Walter H. Fenby, M.D., class of 1894, died at his home in Ruthsburg, Md., November 5, 1910, from acute nephritis, aged 40. He was a member of the Medical and Chirurgical Faculty of Maryland.

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Thomas M. Chaney, M.D., class of 1866, of Chaney, Md., died at his home December 6, 1910, from the effects of a nervous breakdown. Dr. Chaney was born in 1841.

Dr. Chaney graduated from Dickinson College, Carlisle, Pa., in 1862, and later from the Medical School of the University of Maryland. He is survived by his widow (Mrs. Emma Chaney) and seven children (Lieutenant Eugene Chaney, United States Army, who is now in the Philippines; Dr. Morris Chaney, Prof. Calvert Chaney, and the Misses Grace, Lillian, Josephine and Martha Chaney).

Dr. Chaney served as a post surgeon in the United States Army and was assigned to duty at Newbern, N. C., and at the Army Hospital, which was located on Camden street, Baltimore.

Two years ago Dr. Chaney was elected president of the Medical Alumni Association of the University of Maryland. He had a large practice and was widely known.

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Dr. John T. Wilkins, class of 1851, died at his home at Cape Charles, Va., November 16, 1910, aged 90 years.

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Dr. David Lynn Magruder, class of 1849, Brigadier-General, Medical Corps, U. S. A., died at his home at Bryn Mawr, Pa., November 22, 1910, aged 85. He entered the army as an assistant surgeon in 1850, was made captain five years later. In 1862 he was promoted to major, in 1886 to colonel, and was retired April 23, 1889, because of age. He served as medical director of the Department of the Missouri at St. Louis until October, 1863, and then became chief medical purveyor at Louisville. After service as medical director of the departments of the Platte and the Arizona he again served as medical director of the Department of the Missouri until 1884. He was brevetted lieutenant-colonel in 1865 for faithful and meritorious service during the war, and was advanced to brigadier-general on the retired list in 1904 because of his services during the Civil War.

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## DISEASES OF TONGUE, WITH EXHIBITION OF CASE.\*

By CLAUD SMINK, M.D., Class of 1909.

From what I have heard, the tongue stood in the same relation to the practitioner years ago as the barometer to the sailor. By it and its appearance he shaped his treatment and his prognosis of the case. From its appearance he oftentimes made his diagnosis. While it is possible that he erred in relying too much on its appearance, it is probable that the pendulum has swung back, and most physicians of today err in not paying sufficient attention to it. Years ago they had different kinds of tongue for each different disease, and while this is not in any sense true, still there are many ideas of diagnostic value to be gotten by its inspection. Witness, the tongue in typhoid, with its clear, red border and coated, cracked and dry center, and later the tremor and halting protrusion, showing that the toxines are acting on the nerves and muscles of the tongue in exactly the same way as on those of the heart, where it is shown by the dicrotic pulse. Then the very red, strawberry tongue of beginning scarlet fever or the exanthemata, the pallid tongue of anemia, the dry tongue seen in mouth-breathing in children with adenoids, and also in various adynamic states. The flabby, swollen, teeth-indented tongue, covered with yellow, pasty fur, indicative of chronic gastritis, seen in heavy drinkers and smokers; unilateral furring of the tongue seen in unilateral paralysis and consequent interference with mechanical cleansing, also in a neuralgic affection of the second and third division of the fifth nerve. Then, the grayish coating of thrush, with its small patches,—and so it would go on for a long while if time permitted.

However, these are sufficient to show that it will always bear inspection.

In speaking of the ulcerative conditions of the tongue, for the sake of simplicity and brevity, I have adopted the classification of Sajou, namely, simple ulcers; syphilitic ulcers, tubercular ulcers and malignant ulcers.

As to simple ulcers, they are due to carious teeth or traumatism of some kind.

Butlin says: "A cause can be found for all of these," and that its correction will cure them.

Now, under the heading of simple ulcers we must include the dyspeptic ulcer, caused by indiscretion in diet; the herpetic ulcer occurring in children, the causative agent of which is not clear. These yield to general tonic treatment and purgatives. Ulceration of the fraenum of the tongue is frequently seen in children coughing a great deal, due to the rubbing of the teeth during coughing, especially seen in whooping-cough.

Then, we have mercurial ulcers in ptalism.

Keen's surgery describes the simple ulcers this way: It is an indolent, chronic, painful sore usually, the edges of which are thick, but seldom hard, and the raw surface of which is destitute of granulation. At times the edges become thickened, and it may be necessary to differentiate it from a carcinomatous ulcer, and, indeed, the scar from a chronic simple ulcer seems to be often the site for the beginning of an epitheliomatous growth.

As to the treatment of a simple ulcer, the removal of the cause, care in diet and habits and avoidance of irritation of any kind whatever to the part, as smoking, drinking, eating hot and cold food, use of vinegar, mustard and pepper, will bring about a healing. All carious teeth should, of course, be removed. The ulcer may be painted once a day with a solution of chromic acid, five grains to the ounce of water, but silver nitrate should not be used on a simple ulcer, as its irritating effect predisposes to cancer. I may say that

\*Read before the University of Maryland Medical Society  
November 15, 1910.

silver nitrate had best be kept away from the tongue. A chronic ulcer with thickened edges should be removed by means of an elliptical incision and the edges of the wound approximated with silk sutures.

The diagnosis of a simple ulcer from a syphilitic one is made first by the history, then the situation of the ulcer; for instance, close to a jagged tooth or some other irritating cause. Secondly, there is a lack of induration, and the adjacent parts are red and oedematous and the ulcer forms much faster than a syphilitic one.

A primary lesion may be diagnosed by the early enlargement of the glands and its induration and slow growth.

The gummatous ulcer is of much greater depth than a simple one; its edges overhang. Ofttimes the induration is great and there is an adherent slough. Here again we have the other points of differentiation which syphilis gives us. From a tubercular ulcer it is diagnosed by its regularity in outline, as opposed to irregularity of tubercular ulceration. Tubercular ulceration is deeper, covered with oedematous granulation, and much more painful.

Again, tubercular ulceration of the tongue is seldom, if ever, a primary tubercular focus, being usually preceded by laryngeal, or pulmonary involvement.

From sarcoma, a simple ulcer is diagnosed by the age of the person, by microscopic examination, glandular enlargement, more severe pain, and by the fact that a definite cause can be found for simple ulcers, on the removal of which prompt cure will be effected.

As to the second class of ulcerations, the syphilitic ulcer of the tongue, these occur in all three stages of the disease. The primary lesion or chancre may occur, usually at the edge of the tongue, followed by the regular syphilitic manifestations. It begins as a slow, painless, irritable indurated sore, with early glandular enlargement, and promptly disappears under mercurial treatment.

The mucous patch of the second stage may become irritated and cause furrow and fissures and later inflame the whole tongue, and gumma of the third stage may occur in the tongue. Usually these are multiple, several occurring at the same time, and later breaking down to form a deep ulcer, with ragged edges, widely indurated, situated in the middle of the tongue.

From the tubercular it can be diagnosed by the history, by greater induration, by absence of laryngeal or pulmonary involvement, by response to treatment, by general glandular enlargement and by the lack of the oedematous granulations seen in tubercular ulceration. The spirocheta can be found and the tubercular bacilli in the other.

The third case, or tubercular ulcers, are very rare, and when they are seen, are seen usually in men. It occurs in a variety of forms. First, we have the cold abscess, occurring on the dorsum of the tongue, and about the size of a hazelnut. These are very slow to rupture, situated deeply, and the mucous membrane may be movable over them.

Second, we have the tuberculous nodule, which consists of many little tubercles. This occurs mainly in young subjects, and almost always near the tip of the tongue. When it ruptures we have an ulcer. The tuberculous fissured ulcer so often spoken of is caused by a tubercular nodule breaking by means of a fissure, and not an ulcer. Material scraped from an ulcer of this kind often has bacilli in it. The tuberculous papilla spoken of in the older books are caused by tubercular infiltration elevating the epithelium at points on the tongue and fissures forming between these elevations.

The condition known as lupus of the tongue occurs in young girls, and usually during the progress of lupus of the skin. The disease area is a crusted irregular sore, which shows distinctly a pinkish nodular floor beneath it. The occurrence of this condition has been denied, but Butlin has seen several cases. Nothing benefits it much, although iodoform, X-ray, tuberculin and various mouth washes are used.

The typical tuberculous ulcer, such as I have seen, is a sore with a rough, uneven floor, covered with pale oedematous granulations and discharging a thick, yellowish material. As a rule, there is no surrounding induration or inflammation. Usually they are multiple, and near the tip of the tongue. They occur mainly in young adults. They are almost uniformly fatal in two years; at least, the patient usually dies in two years. Contrary to most tubercular processes, the pain is often excruciating, and it is sometimes necessary to cut the nerve supply to the tongue to bring about a cessation of the terrific agony.

The diagnosis is from syphilis and cancer. I have already shown the diagnosis from syphilis.

With cancer it is often hard to diagnose, and, according to the American Textbook, the tongue has several times been removed for this ulcer, under the belief that it was malignant.

There is little, if any, induration in the tubercular ulcer, while there is great induration in cancer. Cancer is hard, friable, bleeds easily, while tubercular ulcer is just the opposite. It occurs in young people. Cancer occurs in old people. There is tuberculosis somewhere else in the patient, usually the larynx or the lungs. Inoculation experiments and microscopical examinations will prove the diagnosis of cancer if it be present.

As to treatment, all tubercular ulcers should be extirpated along with the glands in the neck. It is very prone to recurrence. If it is impossible to operate, palliative measures should be used. Abstinence from all irritating food, cleanliness of the mouth and the usual tubercular treatment are indicated. Butlin uses iodoform, morphia and borax rubbed in several times a day. Some advise the use of the thermo-cautery; some condemn its use.

And now, to the most important form of ulceration of the tongue, namely, cancer of the tongue. I will not deal with sarcoma, as it is so very rare, and so what I say may be considered as applied to epitheliomata only.

Etiology of epithelioma of the tongue is that of cancer anywhere. However, there are many predisposing causes, and a few of these are worthy of mention. For instance, in 16 out of 80 cases it was preceded by leukoplakia, or psoriasis of the tongue, and this, in turn, is thought to be due to excessive use of alcohol and tobacco. Very often it begins in the scar produced by syphilis or traumatism. It sometimes occurs at the point where the pipe stem rests on the tongue, or opposite a jagged tooth. Keen has observed its occurrence in a man who had carried nails in his mouth in his work for some years. Sometimes cauterization of a simple ulcer helps it along. There is no doubt that it may occur here as elsewhere without previous irritation, but in many cases history of previous irritation can be elicited. Therefore, it behooves us to be careful how we use caustics on simple ulcers of the tongue, and especially after 40 years of age. Butlin believes that any warty growth will become cancerous if left on the tongue.

The prognosis of cancer of the tongue varies with the time at which it is seen by the surgeon; however, unoperated cases are uniformly fatal in a period varying from seven months to two years.

As to the signs and symptoms and course of the disease. It may begin as a chronic ulcer at the margin of the tongue. A nodule may ulcerate; a fissure may form in a chronically inflamed area. A papilloma may become malignant, or a cancer may start as a pure and simple cancerous ulceration.

They spring from the squamous epithelium of the tongue almost always, and one arising from the glandular epithelium is indeed a rarity. Fully developed, it is a foul, irregular ulcer, with a rough, uneven, sloughy floor, and rolled out, knobby, hardened, projecting edges. Around this is an extensive area of dense infiltration. There is also a warty form where it takes on the appearance of a fissured, warty, elevated surface.

Early, very early, in the condition we find enlarged, infected lymph glands of the neck. They are affected before they are palpable, so should be removed en masse, even if they cannot be felt. A cancer of the tip involves first the submental, mental, submaxillary, and parotid, and one of the back of the tongue first gets the upper and lower groups of deep cervical glands; however, Owens says that "the unhappy feature in the lymphatics of the tongue is that they do not observe the anatomic precision which nerves, arteries and veins are accustomed to follow, but passing across the tongue, bring infection to the glands of both sides of the neck, while the cancer may still be small and on one side. Pain is usually severe, and begins early. In a cancer located at the posterior part of the tongue it is first felt in the ear. Food or drink aggravates the pain; movement aggravates it; stiffness of the tongue supervenes; articulation is muffled and painful, dribbling of saliva and later a foul, offensive pus occurs. As the growth spreads, the mouth cannot be opened far; swallowing is difficult, and sometimes impossible; breathing may be interfered with; tracheotomy may be necessary. When it spreads to the pharynx and other parts sloughing may cause fatal hemorrhage. Ever present is the danger of bronchial pneumonia from inhalation of the septic product. Death is due to hemorrhage, sepsis, exhaustion, gastro-intestinal disturbances or bronchial pneumonia, and always in less than two years. The early death is due to the fact that constant contraction of the tongue muscles forces carcinoma cells into the tissues.

As to diagnosis: I would say that it behooves us to make a diagnosis early if we wish to throw out any hope of cure by operation. The main

things with which it can be confused are syphilis and tuberculosis. I have spoken of these before.

*History, Section, Appearance, Age, Other Symptoms, Number, Other Involvements, Apparent Cause, Etc.*

So far as the treatment is concerned, we all know the treatment of cancer is mainly by the knife, and it only remains, then, for us to discuss the ways and means of accomplishing the ultimate aim, namely, eradication. I do not think that cancer of the tongue has ever been cured except by the knife, at least I saw no instance of it in the literature. We can divide the cases into three classes:

First—Those offering chance of cure by operation.

Second—Those for whom operation would only prolong life and alleviate symptoms.

Third—Those cases where an operation would be of no use.

This third group comprises those cases where the jaw, pharynx, palate and epiglottis are involved and exhaustion marked.

The second class are benefited, in that life is prolonged and they die easier, because death from recurrence in the glands of the neck is not so painful as death from the primary growth.

As to the method of operating: I will not describe it, but will merely mention a few of the most important methods. It is generally conceded that if the cancer is very early, and on one side of the tongue, it is sufficient to take out that side of the tongue and the glands of the neck. This is very important, as the stump of the tongue is a very useful thing. Take out healthy tissue, three-quarters of an inch around the growth. A growth at the base of the tongue demands removal of the whole organ. It is always best to clean out the glands on both sides of the neck, and Crile of Cleveland takes out the internal jugular along with the anterior triangle. The usual method is to remove the glands and tie off the linguals, and latter, when this wound is almost healed, to take out the tongue. It is sometimes divided into three operations. The tongue itself may be removed by the Whitehead method, which consists in making a strong traction on the tongue and dividing the frenum and attachment of the tongue by a series of short cuts with the scissors. If the lingual arteries have not been tied, they may be picked up as they are cut. The stump should

be kept under control by means of a ligature passed through the glosso-epiglottidean fold for at least 24 hours. Kocher's operation is seldom used, and consisted, briefly, in sawing through the lower jaw in the midline, removing tongue, tonsil, soft palate, anything affected, with the thermo-cautery, covering the raw surface with Xeroform, wiring the lower jaw and instituting drainage just above the hyoid bone. A later method is to draw the tongue out through the wound below the jawbone and remove it. Very important is the matter of getting the mouth cleaned before the operation. It behooves us also to remember the danger of septic pneumonia after operation. So it is well to keep the mouth clean by use of various antiseptic mouth washes, and various varnishes have also been recommended. The patient is fed by the rectum for the first days and later by means of a tube. It is well to get the patient up the day following the operation.

I will now speak very, very briefly of some other conditions found in the tongue. Congenital absence of the tongue occurs. Bifid tongue occurs, and should be corrected early if it interferes with nursing. Tongue-tie is usually in the mother's imagination. However, if it interferes with nursing, it should be cut. As there have been fatal cases of bleeding from this slight operation, it is best to be careful. The tongue should be raised and only the reflection of the mucous membrane cut. It is seldom necessary to cut the muscle. The old practice of cutting or tearing it with the finger nail is reprehensible and may lead to infection, and scar-tissue formation, with a greater tying down of the tongue than was present before.

Occasionally idiots and people under anesthesia swallow the tongue. This simply needs mention, as everyone who has given anesthetics has seen it. Wounds of the tongue occur from biting it in convulsions and various forms of traumatism. They heal well, but bleed freely, it often being necessary to anesthetize a patient before they can be gotten at and hemorrhage controlled. Burns and scalds heal quickly under potassium chlorate mouth wash. Stings of the tongue may cause oedema of the glottis.

Inflammation of the tongue, or glossitis, is *acute* and *chronic*.

Acute glossitis is divided into superficial, which is simply an inflammation of the mucous covering the tongue, due to burns, scalds or thrush, and occurring in various fevers and gastro-intestinal

intoxication. Glossitis is further divided into parenchymatous glossitis, of which rare condition I have been fortunate enough to see a case. The cause is unknown; cold predisposes; probably due to infection down the duct of the gland. Begins with a stiffness and thickening of the tongue, pain on movement, and later at all time. The organ becomes enlarged, protrudes from the mouth, saliva dribbles, the temperature is raised, deglutition and articulation are interfered with; dyspnea occurs. This goes on for several days, and either subsides or an abscess develops in the tongue. The treatment of this condition is incision of the dorsum of the tongue. This relieves the condition by relieving the tension. Hemiglossitis is the same condition limited to one side of the tongue. Mercenial glossitis occurs in ptyalism. Abscess of the tongue is either the result of infection down a gland duct, or traumatism, or is the end-result of parenchymatous glossitis. The tongue is, of course, affected in the diseases of the mouth; as, for instance, "thrush." Chronic abscess of the tongue is due to an infection of a tubercular area, or a gumma with pyogenic organisms.

Under the heading of chronic glossitis we have the dyspeptic tongue, which is a chronic superficial glossitis; the geographic tongue, the cause of which is unknown, and which does not give much trouble. Herpes of the tongue also occurs and recurs. Most important, however, of these conditions is leukoplakia, which is so often the forerunner of carcinoma. This is a chronic superficial inflammation involving most frequently the tongue, but sometimes the rest of the mouth. The real cause is unknown, but smoking, gastro-intestinal catarrh, rheumatism and gout seem to predispose. It begins with a red patch, which is irritated by highly seasoned food. Slowly the patch changes to a smooth opalescent or whitish area. These patches frequently run together and form large areas. Cracks, and even ulcers, may occur. The treatment has been very unsatisfactory, and really the best I could find was to keep the mouth clean and remove the probable cause.

Leprosy, actinomycosis and trichinosis have been reported in the tongue. Dermoid cysts and the various forms of benign tumor occasionally occur. The ranula or cysts formed by the plugging of the duct of the glands under the tongue, either mucous or salivary, is well known to us all. Macro-glossia is a cavernous angioma of the submucous connective tissue of the tongue. It af-

fests particularly the anterior three-fourths of the tongue and should be operated on early in life. The operation consists in simply removing a V-shaped portion from the anterior part of the tongue and approximating the edges with silk sutures.

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#### A PARTIAL ANALYSIS OF 500 GASTRO-INTESTINAL CASES AND REPORTS ON TWO OF THEM.\*

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By ALBERT HYNSON CARROLL, M.D.

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All of us are aware of the large number of gastro-intestinal cases which occur among sick children. Perhaps but few students realize how often they will be called upon to diagnose and treat such conditions in adults, on entering upon their life work as doctors.

I wish to call attention to the frequency of these abnormal conditions occurring in adults, and shall base some statements on an analysis of all cases presenting themselves at the University Hospital Dispensary for various ailments.

Exclusive of "children" and "orthopedic cases," nearly 8000 new cases were entered from May, 1909, to May, 1910. During a period of 12 months (November 1, 1909, to November 1, 1910,) over 500 presented themselves for "stomach trouble" alone. In other words, about one in every 16, or 6 1/4 per cent. It appears quite rational to expect this to hold good also in general practice. It does. It is of the greatest importance that the student of medicine should be familiar with the clinical symptoms and methods of diagnosis in gastro-intestinal diseases.

The facilities for gaining such knowledge are very favorable at the University of Maryland. Between 65 and 75 cases are presented by Dr. John C. Hemmeter in his clinics during each scholastic year. In the dispensary over 1700 treatments were given between November 1, 1909, and November 1, 1910, in the "stomach box" alone.

Of these, 65 per cent. were male, 35 per cent. were female; 67 per cent. white and 33 per cent. colored; 72 per cent. were married. The youngest treated was 12 years old and the oldest 67. The average age was 34 years, and the average above 30 years was 42 years.

There were more than 50 distinct "occupations"

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\*These two cases are printed just as they were presented and read at Dr. John C. Hemmeter's clinic.

or methods of making a livelihood. Eliminating "laborers" and "housewives," tailors led in any one vocation, being 6 per cent. of the whole number. Next came machinists, mechanics and metal workers, with about 3 per cent. Then bakers, shoemakers and candymakers, with about 2 per cent.

Occupation appears to have little or no bearing in these dispensary cases. The tailors probably came to us on account of the proximity of numerous clothing factories. The same holds good for the machinists and metal workers. The few cobblers did not show the anatomical deformities we are taught to associate with their trade. The bakers denied tasting hot bread or pastry. The same with the employes of candy factories.

An analysis of a large series of cases showed that 16 per cent. had normal stomach secretions; that 11 per cent. had hyperacidity ranging from 25 degrees to 82 degrees. The remainder, 73 per cent., showed a subacidity or an anacid condition.

In 30 anemic, emaciated or cachexic cases, with no uncombined HCl and Oppler Boas bacilli present, the "bromine water test" failed to give the tryptophan reaction indicative of malignancy. This was disappointing.

Nearly 2 per cent. of the patients presenting themselves with "stomach trouble" were relieved of their symptoms after intestinal parasites had been diagnosed and expelled. A disordered digestion is so often only an index to some remote evil. One case of anacid gastritis was cured by digitalis.

Intestinal obstruction and round ulcers were diagnosed and operated on in the hospital (Professor Smith) (Dr. Spruill). Amebic and tubercular ulcerative dysentery, rumination, gastralgia, malignancy, gall stones, acute and chronic appendicitis, post-operative and other adhesions, pylorospasm and spasm of the cardiac orifice, wind-swallowing and other conditions too numerous to mention here were observed.

Can any student afford to undertake the practice of medicine unless these gastro-intestinal complications are understood and their importance, as regards what the patient calls dyspepsia or indigestion, or constipation or diarrhea, is appreciated?

In a large number of cases the gastric disturbance is only an outward sign of some inward and remote evil. The stomach is often only a mirror reflecting a pathological condition of some of the other abdominal viscera. Remember, the gastric

disturbances accompany a floating kidney, or, again, a retroflexed uterus. How much good would follow lavage, drugs, etc., in such instances? We must be prepared to find and to remedy the primary evil.

But in the dispensary cases by far the largest number suffer as a result of improper diet, poor mastication, vicious habits, lacking or decaying teeth with indescribably filthy oral cavities.

Many of these patients are enteroptic; a surprisingly large percentage in fact, among the older ones. Ptosis, plus a foul mouth!—This is indeed a difficult condition to meet. Diet, lavage, electricity, drugs and bandages may be of use. A system of treatment is as strong as its weakest part. When we remember the mouths of these people it is a marvel that we get as good results as we do! An adequate knowledge of these conditions cannot be had from textbooks alone. The clinics, the ward classes and the dispensary afford ample opportunities to the student.

The two following cases are interesting examples of what each candidate for graduation should be able to do:

CASE I.—A DISPENSARY CASE OF CARDIO-SPASM  
WITH ANACID GASTRITIS, PRESENTED BEFORE  
PROFESSOR HEMMETER'S CLINIC, UNIVERSITY  
OF MARYLAND, BY HENRY B. ATHEY AND F. L.  
BLAIR, CLASS OF 1911.

Dispensary case No. 24,872; name, C. W.; male; white; social condition, married.

*Diagnosis.*—Cardio-spasm with anacid gastritis.

*Hereditary Facts.*—Negative to T. B., cancer, epilepsy, gout, etc.

*Past History.*—The patient gives a history of having had the usual diseases of childhood, such as measles, whooping-cough and chicken-pox. He has not had typhoid fever, diphtheria, scarlet fever, epilepsy or rheumatism. Abdominal diseases, except the present, negative. Negative also to venereal diseases. The patient states that up to two years ago he used alcohol to a moderate extent. His past health has been good.

*Present Complaint.*—The patient states that he has been sickly for the past three or four years, and that every day while eating, when he is about half through, he experiences considerable pain under the sternum and vomits sour food at the time. He further states that, as expressed in his own terms, "he is able to prevent this vomiting by getting up and jolting the food down into his

stomach while walking around." Again, he informs us that the drinking of a glass of cold water washes the food down and thereby at times relieves him of the "necessity" of jolting the food down. Hot coffee, hot tea, etc., or hot water at any time will regurgitate, and also prevent other food from passing into his stomach for several minutes. He has pains in the right and left hypochondriac regions, which radiate to the left lumbar region.

The patient is miserably constipated, stating that there is frequently a lapse of a week or more without a movement unless he takes something to relieve the condition (castor oil or salts).

He has complained for some time of chilly sensations, and states that he does not "sweat" even in the summer. He has severe frontal headaches. Eruption is frequent and relieves him considerably of his distress. At times, the patient states, the pain in the epigastrium is so great that fainting spells are induced, which symptoms are relieved by vomiting. He can't eat meat or fried food. He is "very nervous."

*Physical Examination.*—General inspection shows the patient to be emaciated, anemic, and quite nervous and weak.

*Mouth.*—The teeth are in poor condition. Tongue is coated rather thickly and is whitish in color. His breath is extremely foul. His gums are retracted and soft.

*Eyes.*—Reflexes are normal—react to light and accommodation. Conjunctiva not yellowish.

*Ears.*—Show nothing.

*Heart.*—Normal in position and sounds.

*Lungs.*—Negative. The thoracic cavity is long, narrow and somewhat funnel-shaped. There are two floating tenth ribs.

*Liver.*—Dulness extends about a finger's breadth below margin of rib. Numerous dilated subcutaneous vessels are seen in the right umbilical region (not a "caput medusæ").

*Kidneys.*—Not palpable. No edema of the ankles.

*Spleen.*—Not palpable.

*Stomach.*—The stomach is slightly distended, extending to within an inch above the umbilicus. As stated above, there are two floating tenth ribs, with an angle of 68 degrees, but he is not "enteroptie."

*Romberg's Sign.*—Negative.

Knee reflexes absent.

*Measurements.*—M. X., 9 inches; M. U., 15 inches; M. S., 19 $\frac{1}{4}$  inches; X. R. S., 9 inches;

X. L. S., 9 inches; S. S., 9 $\frac{1}{2}$  inches; C. at X., 33 inches; angle at X., 68 degrees; height, 5 feet 3 $\frac{1}{2}$  inches; present weight, 120 pounds; previous weight, 160 pounds (two years ago).

*Blood.*—A differential blood count was not made. Hemoglobin is 40 per cent. No evidence of malaria. Relation of whites to reds apparently normal. Reds, 2,500,000.

*Sputum.*—Negative to T. B.

*Urine.*—Negative to albumen, sugar, casts and indican in excess.

*Feces.*—Of a peculiar yellow color, of pasty consistency, and not particularly odorous. Occult blood and mucus negative. Bile-stained particles present. No intestinal parasites or ova present. No undigested meat cells. Some mucus.

The low percentage of hemoglobin and anemic condition of the patient might suggest possible malignancy, but we do not believe this to be the case. Nor is the loss of weight, in our opinion, to be attributed to tuberculosis. We have ascribed it to malnutrition alone.

The etiology in this case of spasm of the cardiac orifice is not traumatic, but is clearly a neurosis.

*Examination of Stomach Contents After Test Meals.*—On October 25, 1910, stomach contents showed no free hydrochloric acid. The total acidity was 30; lactic acid present, but the tryptophan reaction was absent. Much mucus, and food poorly digested. The patient was put on a bland diet, given lavage daily, strychnine sulphate, gr. 1/30 t. i. d. and hydrochloric acid gtt. 30 t. i. d. in water after meals. Lapactic pills were also ordered temporarily for his constipation. A mouth wash was ordered. On November 1, 1910, a second examination of stomach contents was made, at which time free hydrochloric acid was found to be 8, with a total acidity of 38. At this time the patient seemed somewhat improved, and stated that he had not vomited very often since treatment was begun.

Later findings in the case led us to look for dilation of the esophagus. The tube on all occasions had been passed without marked difficulty, however. Esophageal dilatation was tested for by giving the patient two ounces of hot water with the tube introduced about 25 cm. On withdrawing, 20 cc. of clear fluid was obtained.

*Later Treatment.*—We did not change the previous treatment, except that we substituted iron, quinine and strychnine for the strychnine sulphate. Bromides and dilation of the cardiac

orifice of the stomach might result in benefit in this case. His condition has been thoroughly explained to him. He has been told to eat small quantities of food at frequent intervals; that his trouble is a serious one, but that the accompanying gastritis will surely improve under treatment; that it may be necessary to dilate the opening into his stomach. This he refused. He has been warned against eating pastry, fatty or fried foods, and has also been told that strength must be gained by eating such things as boiled rice, mashed potatoes, stewed fruits, scraped beef, meat broths, milk, spinach, eggs, boiled fish, etc.

Since the above history was read in the clinic, in accordance with Professor Hemmeter's suggestion, a radiograph was obtained with a view to determining positively, if possible, whether or not esophageal dilatation was present. The picture, however, was somewhat faulty and did not accurately show the field, although a shadow was visible at the cardiac orifice of the stomach. The following day the patient was again in the dispensary, and, feeling confident of the existence of cardio-spasm and of esophageal dilatation, we again tested for this by giving the patient a warm solution of methylene blue. On inserting the tube 25-30 cm. a few seconds later, a clear solution of methylene blue was obtained, and this, together with the symptoms and other findings, seems to warrant us in arriving at the diagnosis of cardio-spasm in addition to the anacid gastritis.

*Prognosis.*—Must be guarded. The anacid condition is more likely to respond to treatment than the cardio-spasm. Immediate dilation is urgent. The patient is starving! Even dilation not infrequently fails to overcome this condition.

#### CASE 2.—GASTRIC ULCER.

Name, C. O.; sex, male; color, black; age, 30; social condition, married; residence, X alley; occupation, stevedore, in which occupation abdomen was used very much for pushing trucks.

*Complaint.*—"Stomach trouble."

*Diagnosis.*—Gastric ulcer.

*Family History.*—Father died at 55; cause, "abscess of stomach." There was a history of coffee-ground vomitus. Mother died at 62. She was the victim of asthma. Probable cause of death, from history, was an intercurrent pneumonia. Three brothers and two sisters living and in good health. Negative to pulmonary, cardiac, renal, nervous diseases and to syphilis and malignancy.

*Past History.*—Has had chicken-pox, measles,

mumps and whooping-cough. These diseases were during childhood, and there were no complications or sequelæ.

Negative to scarlet fever, diphtheria, pneumonia, typhoid or malaria.

*General History.*—Gonorrhea five years ago; a second attack about two years ago. The discharge in both cases soon cleared up and neither attack inconvenienced or troubled him much.

Negative to ulcers of penis or evidences of syphilis.

*Habits.*—Has been a "heavy drinker and eater of highly seasoned foods."

*History of Present Illness.*—Probable exciting cause alcoholic excesses and work in which abdomen was the site of great pressure.

Last Easter patient was taken with a severe tonsillitis. Soon after recovery from this he noticed a dull uncomfortable feeling about the epigastric and left hypochondriac regions. Soon this uncomfortable feeling became one of pain and was accompanied by frequent vomiting. A physician was called and treated him for about two months. At the end of this time patient was discharged apparently well. Three weeks after being discharged he started drinking and went on a "pretty good spree." A few days after this spree he complained of a dull pain, most marked in the umbilical region, radiating over entire abdomen and to the back, gradually getting worse, vomiting whenever he ate or drank anything.

Patient then came to the dispensary here; a test meal was ordered, but not obtained. Two days later he returned to the dispensary. At this time an attempt to pass the stomach tube produced vomiting, which vomitus contained bright red blood. On October 28 patient entered the hospital with the following symptoms:

#### Gastro-intestinal.

Appetite good, rather large. Thirst increased. Foul odor in expired air. About 15 minutes after eating, even after drinking water, patient has a gagging spell, followed by vomiting of contents of stomach, often of a dark coffee-ground appearance. This typical "coffee-ground" vomit was shown to each and every senior student (class 1911) by Dr. Carroll. At times during the night patient is awakened with a sudden nausea and vomiting.

Does not complain of fullness after eating, eructations or distention of stomach with gas.

Pain is constant, most marked about 1½ inches to the left of umbilicus, radiating over entire ab-

domen and into the back. After ingestion, pain seems increased until relieved by vomiting. Sour food increases pain.

Jaundice negative.

At times a burning feeling in left hypochondrium and epigastrium, running up beneath sternum, accompanied by "water-brash."

Bowels constipated; at times tarry stools; no hemorrhoids.

Nervous, renal, cardiac and pulmonary symptoms are negative.

*Physical Examination.*—At time of examination patient was in dorsal decubitus position and appeared to be suffering great pain. Patient, a well-developed negro, weight about 170 pounds, height about 5 feet 11 inches. Facial expression anxious, evidencing pain. Skin elastic and of good tone.

Muscles large, firm and quick acting.

Bones large and thick.

Head covered with thick growth of dark, curly hair.

Ears normal.

Hearing good; eyelids normal, no puffiness. Conjunctiva normal and of good color. Ocular movements good. Sclera thick white.

Pupils equal, react to light and accommodation.

Nose normal, no evidence of disease.

Mouth—teeth are in fairly good condition. Tongue coated with white fur.

Neck, no abnormal pulsations, no glandular enlargement, no rigidity or evidences of pain.

Chest, breast-sounds of good volume and intensity; no rales heard.

Heart, area of dullness about normal, no murmurs, sounds clear, rhythm regular.

Abdomen, intercostal 72°.

Liver dullness normal on percussion.

Muscular spasm of left rectus.

Palpation reveals tenderness, most marked about 1½ inches to the left of the umbilicus; no evidences of tremor. Two floating tenth ribs.

Percussion shows the stomach to be normal in size and position.

Spleen normal. Kidneys not palpable. No distention of abdomen.

Measurements: M. to X., 18 inches; M. to U., 14 inches; M. to S., 19½ inches; S. to S., 9 inches; C. at X., 31 inches; Angle at X., 72°.

X-ray was made November 5, 1910, 6 P. M. Bisubcarb given at 3 P. M.

*Treatment.*—Immediately on entrance patient was put to bed. Nothing by mouth. Ice cap over abdomen. One-quarter gr. doses of morphine given hypodermically. On second day small amounts of liquids were given by mouth and morphine discontinued. Pain gradually subsided. The day previous to operation there was scarcely any pain. On November 1 a gastro-enterostomy was done by Dr. Spruill. Operation revealed a large gastric ulcer situated at the lesser curvature.

The patient made an uneventful recovery and was discharged on the twenty-eighth day after admission.

#### CAUGHRMAN AND BYERLY, CLASS OF 1910.

This case should serve as a warning. The first time he came to my clinic, his complaints, habits, history of having been a hard drinker, etc., led me to believe this to be a case of chronic gastritis. Being pressed for time, he was given Strych. Sulph. and hydrochloric acid (an almost inex-  
cusable error). The moral is: "Be sure you are right in your diagnosis first." Learn to diagnose gastro-intestinal diseases now, when the opportunity offers.

[Dr. John Houff has aided me greatly in sending to my department in the dispensary only true "gastro-enterologic" patients.  
A. H. C.]

#### INFANT-FEEDING.

By Nathan Winslow, M.D.

(Continued from December number.)

*Artificial Foods.*—All artificial preparations are inferior to properly-modified cow's, consequently to mother's, milk, but may often be advantageously employed as a temporary expedient. It must be remembered their continuous ingestion predisposes to rickets and intestinal disturbances. The commonly-used infant's foods may be grouped as follows:

(1) *Milk Foods.*—Nesle's, the most widely known of these, consists of milk evaporated to dryness, to which powder-scoured wheat flour has been added. Analysis shows little or no fat or proteids, but the presence of a great excess of carbohydrates, especially in the form of starch, to wit., F., 5.48 per cent.; P., 11 per cent.; cane sugar, 30 per cent.; milk sugar, 7.60 per cent.; starch, 29.95 per cent. As the stomach of the child is capable of digesting only proteids of animal origin, Nesle's food, a pure and simple derivative of the vegetable kingdom, will, if its use is persisted in, work untold injury to the recipient's digestive apparatus. Other preparations re-

sembling it in composition are the Anglo-Swiss, Franco-Swiss and Gerber's food.

(2) *Malted Foods*.—Of these Mellin's food is the best example. It consists of wheat and barley flour which have been converted into dextrose, dextrine and maltose. It is composed of 80 per cent. sugar; the fat is less than 1 per cent., and the proteids are very small in amount. Other articles classified under this category are Liebig's, Horlick's and Hawley's food.

(3) *Farinaceous Foods*.—Ridge's may be taken as a fair example of this variety of infant's food. It consists of 1 per cent. fat, 11.93 per cent. proteids, 2.91 per cent. soluble carbohydrates and 77.96 per cent. insoluble carbohydrates. Other foods more or less resembling it are Imperial Granum, Hubbell's Prepared Wheat and Robinson's Patent Barley.

(4) *Miscellaneous Foods*.—Carrick's consists of more than one-half unchanged starch, and the fat is chiefly cocoa butter. Lacto Preparata differs from the above in that milk sugar replaces the starch. Lactated food is composed of 75 per cent. carbohydrates, of which nearly one-half is unchanged starch.

The great differences between these foods and cow's and breast milk to be remembered are the small amount of fat and the exceedingly large amount of carbohydrates, most of which is unchanged starch; finally, the proteids are more vegetable than animal. Consequently these foods are not capable of supplying the rapidly-growing child with proper nourishment. They can be employed beneficially when you desire to tide over some great crisis, but under no circumstances depend upon them to the exclusion of everything else. Remember, then, as these foods consist of sugar, children apparently thrive upon them for a few months, and their increase in weight borders on the phenomenal, but in the end the digestion is upset, indigestion supervenes and all the apparent benefit is soon lost. At last, the manufacturers have realized the insufficiency of these articles as an absolute diet, and now advise the addition of cow's milk to them.

*Condensed Milk*.—Condensed milk consists of ordinary cow's milk sterilized and evaporated to one-quarter of its original volume, to which prodigious quantities of cane sugar have been added to make up for the lactose lost during the process of condensation. Analysis would show that it is sterile, with a fat percentage of 16, pro-

teid ratio of 16 and a sugar proportion of 50. As ordinarily administered, it is deficient in fat, but it is very digestible when diluted 12 times. The fat deficiency does not give rise to any digestive disturbances, but tends to produce constiveness, and the bones manifest a lack of development. Whenever a child is fed on condensed milk, you should from time to time dilute it with cream. When you are dealing with infectious diseases, it may not be advisable to use milk, because the chemical activity of the gastric juices for converting proteids into peptones may be in abeyance, the digestive ferments only being able to transform the proteids into albumoses, substances extremely poisonous to the human economy. The temporary use of condensed milk as a therapeutic agent is permissible, but not as an article of diet. As it lacks fat and contains too much carbohydrates, it cannot be depended upon as a permanent food.

*Egg Albumen*.—When all other nourishment fails, egg water, *i. e.*, the white of an egg strained through cheesecloth into three or six ounces of water and flavored with lemon or sherry wine, is many times not only beneficial, but well borne by the stomach.

*Beef Juice*.—Some physicians prefer beef juice, an agent of decided value and merit, being a tonic to the stomach, with little or no nutrition, but easy of digestion. It is simple to prepare—merely broil a lean steak and express the essence with a lemon squeezer. A pound of beef will usually yield two to three ounces of juice of 1 per cent. proteid composition, which should be flavored with salt and pepper and given to the patient warm, but not hot, as heat coagulates the albumen. The method of preparing beef juice described above is known as the dry. When the wet method is employed, a pound of beef is placed in four to five ounces of water, and allowed to stand six to twelve hours in a covered jar, after which the meat is removed and pressed in a lemon squeezer.

Strictly speaking, beef juice is not a food, but is a good stimulant. These extracts, added to milk during the latter part of the first year and throughout the second, enhances its nutritive value, or in indigestion when milk is not admissible. In indigestion, when milk is contraindicated, beef juice often suffices to satisfy the child until a stronger diet can be instituted.

*Broths*.—Good broths may be prepared by the addition of a pint of water to a pound of lean veal, beef or chicken. This mixture is allowed

to stand four or five hours, then cooked over a slow fire for an hour and evaporated to one-half the original quantity. Set the solution aside to cool, then skim off the fat and strain through a cloth.

Although broths are not very nutritious, they are stimulating and are useful when milk has to be withheld, but are not adapted to prolonged use.

*Barley, Rice and Oatmeal Water.*—To prepare these starchy foods, two tablespoonsful of barley, rice or oatmeal grain is added to a quart of water, then boiled for six hours, always keeping the solution up to a quart by the occasional addition of water. After being fully cooked the gruel is strained through cheese cloth. When cooled the abstract will solidify into a thin jelly, to which salt should be added to make it more palatable. In constipated subjects oatmeal gruel should be awarded the preference, but in diarrhea rice or barley water is the better food.

*Sterilized Milk.*—By sterilization the bacteria are destroyed, consequently fermentation of the milk prevented for several days. The germs most frequently present are saprophytic in nature; even these under favorable environment are responsible for some forms of diarrhea. The tubercle bacillus may be introduced from the outside or may be derived from the cow direct. Other organisms occasionally contaminating milk are cholera spirillum, typhoid bacillus and the bacillus of diphtheria. In order to eliminate these obnoxious agents the temperature of milk was formerly raised to 212° F. and maintained at that high elevation for an hour and a half. When treated by this process milk will keep a week, but it is bitter, repulsive to the taste, brownish in color, as a portion of the sugar has been converted to caramel. Children fed on this product are prone to constipation, but it is preferable to doubtful milk, especially during the hot summer months in large cities. The Arnold sterilizer may be employed for this purpose. Pasteurizing of the milk is now preferred to sterilizing, because the liquid is only heated to 167° F., for at this temperature, continuously applied for 20 minutes, the cholera, typhus, diphtheria, tubercle and coli communis organisms are destroyed and the milk can be kept at the room temperature for two days. Freeman's pasteurizer is a good apparatus for this purpose. By this method there is no apparent change in the composition of the milk nor untoward effect upon the nutrition of the child

by the use of milk treated by this process. Bear in mind, however, that pasteurized milk has to be modified just as carefully as the unpasteurized variety. If undiluted it will cause just as much disturbance as unpasteurized. It has no therapeutic value, but only prevents disease.

*Peptonized Milk.*—In order to accomplish the peptonization of milk, pancreatin, a derivative of the pancreas of the pig, is added to the milk. As this substance is active only in an alkaline medium, bicarbonate of soda must be added to the milk.

*Partially Peptonized Milk.*—To one pint of fresh cow's milk four ounces of water and a powder containing 5 grains of pancreatin and 15 grains of bicarbonate of soda are added. This mixture is poured into a glass jar and set in a water bath with a temperature of 105 to 115°. i. e., as hot as can be well borne by the hand and kept there from 6 to 20 minutes, shaking the solution from time to time. Peptonizing powders can be obtained put up in glass tubes, each tube containing enough of the powder to pasteurize one pint of milk. If milk is peptonized 10 minutes its taste is not altered. After 20 minutes treatment there is a formation of peptones, which impart a slightly bitter taste to the milk. When we want to stop the action of the peptonizing agent, the temperature of the milk is raised to the boiling point and the ferment is destroyed. Milk destined for immediate use need not have its temperature raised.

*Completely Peptonized Milk.*—The steps of complete peptonization differs from the above described method only in the length of time employed, two hours being necessary to convert all the proteids into peptones. If acid is added to the end product, no coagulation ensues. Orange or lemon juice tends to cover the bad taste of this solution. It has been found more desirable to regulate the composition of the milk before pasteurizing, as it will then be ready for use without further handling. Do not use peptonized milk when the stomach is able to stand plain or modified cow's milk.

*Care of Bottles and Nipples.*—Never use a bottle that cannot be cleansed easily. The round bottle is probably the best, as it has no angles. Graduated bottles are more convenient than the others. The best nipple is the plain black rubber one that slips over the neck of the bottle. Never allow the use of nipples with a glass stem at-

tached, as they are very hard to clean. The openings in the nipple should be only large enough to allow the milk to drop rapidly. Keep the bottles full of water when not in use. After use cleanse them carefully by rinsing them in cold water; then wash with a bottle cleaner and hot soap suds. Sterilize them for 20 minutes before pouring in the milk. Do not allow the child to sleep with the nipple in its mouth, nurse longer than 20 minutes, nor have the bottle warmed over for the second feeding. The attendant should hold the child when it is feeding and should see that the bottle is held in such a position that the baby gets milk and not air. The child should be given the bottle at regular periods.

*Mixed Feeding.*—If you are confronted with a woman supplying a good quality of milk, though deficient in amount, the child should not be weaned, but should be allowed enough artificially prepared food to supply the deficiency. Accustom the child to take water from the bottle at least once daily.

SCHEME FOR FEEDING HEALTHY CHILD DURING  
FIRST YEAR.

Age.	Amt. 1 Feed.	Amt. 24 Hrs.	Remarks.
3 to 7 days	1½ oz.	10-15 oz.	{ 10 feeds 24 hrs., at 2 hr. intervals; 2 feeds at night.
2 to 3 wks.	1½-3 oz.	15-20 oz.	{ 10 feeds 24 hrs., at 2 hr. intervals; 2 feeds at night.
4 to 5 wks.	2½-3½ oz.	22-32 oz.	{ 9 feeds 24 hrs., interval 2 hrs.; 1 feed at night.
6 wks. to 3 mos.	3-4½ oz.	24-36 oz.	{ 8 feeds 24 hrs., interval 2½ hrs.; 1 feed at night.
3 to 5 mos.	4-5½ oz.	28-38 oz.	{ 7 feeds 24 hrs., interval 3 hrs.; 1 feed at night.
5 to 9 mos.	5½-7 oz.	33-42 oz.	{ 6 feeds 24 hrs., 3 hr. intervals; no feed at night.
9 to 12 mos.	7½-9 oz.	37-45 oz.	{ 5 feeds 24 hrs., 3½ hr. intervals; no feed at night.

We are in receipt of the following communication from Dr. Robert L. Kennedy, class of 1910, Chattahoochee, a resident physician at the Florida Hospital for the Insane, Chattahoochee, Fla.:

*Hospital Bulletin:*

Gentlemen—Enclosed please find my subscription for the ensuing year. As it has been my good

fortune to see quite a number of cases of pellagra since my connection with the Florida Hospital for the Insane, I thought a few words concerning this interesting malady might not be amiss.

It has been ascribed to many causes, among them being ameba, bad corn, sunlight, etc., but as yet its etiology is a mooted question. A number of different drugs have been prescribed with the hope of finding a specific, with rather indifferent results to date. Arsenic or one of its derivatives has given the most promise. Castor oil, hexamethylin-teramine are highly advocated by some.

The method of treatment followed at this hospital is confinement of patient to bed, restriction of diet and administering of atoxyl in seven-grain doses hypodermically in the gluteal muscles. This dose is repeated on the second day, and then every week until all symptoms save the nervous have subsided. This treatment seems to have done much toward relieving the symptoms, and to have produced in several severe cases an apparent cure. In several instances liquor potassae has been given in 10-grain doses, but it does not seem to exert any particular influence on the course of the disease. Good food and rest are essential. The three most characteristic symptoms are the gastro-intestinal, which is of an inflammatory nature, chiefly asserting itself in a diarrhea which is very obstinate to control, and the severer the case the worse the diarrhea; the cutaneous involvement is anywhere from a slight erythematous blush to a much worse condition, where the skin is cracked open and pretty deeply fissured; it chiefly involves the dorsum of the foot and the legs for a greater or less distance, dorsum of the hands and the forearms and the back of the neck. Of course, it may be found in almost any part of the body. It is of a dark-reddish color. There is a great diversity of nervous symptoms from neurasthenia to acute mania. In conclusion, I would like to say that I know I have not put forth anything new or startling, but I thought that perhaps these words might help to awaken an interest in the subject in some of my Baltimore friends, and thus throw some additional light into this darkened field.

Very truly yours,

ROBERT L. KENNEDY.

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Dr. FitzRandolph Winslow, class of 1906, is now a resident physician at the University Hospital.

# THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, MD., JANUARY 15, 1911.

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## ALUMNI COUNCIL ASSURED.

By the time this issue comes off the press the institution of an Alumni Council of the University of Maryland will be an assured fact. On Wednesday, January 11, at 8.15 P. M., there will be a mass-meeting of the alumni of all departments in Davidge Hall, corner of Lombard and Greene streets, at which a nominating committee will be selected, to whom will be delegated the authority to propose twenty-five names of graduates of ten years standing, five from each department—medicine, law, dental, pharmaceutical, arts and sciences. These twenty-five names will be voted on later by the alumni, and the twenty receiving the largest vote to constitute the Council, no more than four being from each department. The inauguration of this council will mark a distinct departure in the internal management of the affairs of the University of Maryland. Much good should accrue to the University as a result of its formation. Certain functions will be delegated to the council which will bring all alumni into closer relationship with their alma mater. The next issue of the BULLETIN will have more to say on the subject.

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## THE HONOR SYSTEM AN ACTUALITY.

In the November issue of the BULLETIN we had some words on the honor system in the medical department of the University of Maryland. We spoke of the many abortive attempts to institute an honor system, and the reasons in our opinion for the failure. Mention was also

made of the fact that in our estimation, if the students were approached in the proper manner the introduction of the system could be made a go. It now gives us great pleasure to announce to the friends of the University and our alumni that not only has the senior class, but also the entire medical school adopted the honor system, and that it is now in full operation. It is to be hoped now that the ever recurrent criticisms that the examinations were not on the level will be forever silenced. Our men are equal in intelligence, integrity and honor to the student body of any American university, and have demonstrated the fact by the almost unanimous manner in which each class adopted the above-mentioned system. Hereafter there will be no watching during examinations, and a student detected cheating by his classmates will be requested after due trial, if proven guilty, to sever his connection with the institution. The system is on trial; some are watching it with misgivings. Let those vitally concerned with its success show the doubters that the honor system has come to stay.

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## THE ENDOWMENT FUND.

It gives us great pleasure to announce to the friends of the institution that the permanent endowment fund of the University of Maryland has now passed the thirty thousand dollar mark. To be sure, this amount is insignificant to that boasted by some institutions. But let it be remembered that riches have their drawbacks as well as their advantages. A rich institution, as a rich individual, can be arrogant and self-satisfied, but a poor institution in order to keep march with the strides of the times must be ever alert and keen to introduce new methods or else be outdistanced by its competitors. The demands, however, of modern medical education cannot be met from the students' fees, and every school which has any idea of surviving must be on the lookout to increase its permanent funds. The only manner in which this can be done is appealing to the friends of the institution, and we are happy to say that our supporters have come to the aid of the University with the sum above mentioned. Although this sum is entirely too insignificant as yet to be of much benefit to the institution, still it is growing more rapidly

every year. Those contemplating a gift to the University of Maryland can do so with every assurance that the money will be spent in the way indicated, as the fund is governed by an independent Board of Trustees absolutely separate from the professorial staff and incorporated by the Maryland Legislature. The interest alone of this fund can be spent, and that only in the way indicated by the Board of Trustees. If there is no use for the interest it is voted into the principal and at once becomes an integral part of the endowment and is forever inviolable.

It may also be of interest to the alumni and friends of our institution to learn that there are now four active medical scholarships contributed through the generosity of three of our alumni, the Frank, through Mrs. Frank, in honor of the memory of her late husband, Doctor Samuel L. Frank; the two Hitchcock, and the Randolph Winslow scholarships.

The funds of these scholarships are held by the Board of Trustees of the Endowment Fund, and the interest is appropriated annually to meet the expense of some worthy student who would otherwise be compelled to forego his medical education. The bestowal is, of course, subject to certain conditions as regards the scholastic standing of the intended recipient. Twenty-five hundred dollars will establish a scholarship, and in no better manner can a friend help the institution, but he will also be helping some worthy student to complete his education. During the past year the endowment fund has grown by more than ten thousand dollars, and as an active campaign is now being waged to further increase it, we hope next year to announce that it has reached the fifty thousand dollar mark.

## ANNOUNCEMENTS

As we go to press the generous gift of \$5000 of Miss Mary Dashiell Robinson to the University of Maryland Medical School comes to our attention. As far as we know, the gift is hampered by no conditions. It is only another indication of an awakened public interest in the affairs of the University of Maryland which has occurred during the past few years, and wealthy and benevolent people are commencing to remember the University in their wills. We feel

that all of our alumni will be gratified to hear of this gift.

The Executive Committee and the Board of Directors of the General Alumni Association has decided to give a theater party at Ford's Opera House, Monday evening, February 6, 1911. The performance will be by Cohen and Harris' Minstrels, an entertainment which has been received with marked success in New York and other large American cities. The object of the theater party is to eliminate a debt which has been a drawback to the General Alumni Association for several years. It is hoped that a sufficient sum will be realized not only to pay this debt, but also to place the scheme of the Alumni Advisory Council on a safe footing. Your committee hopes that you will show your interest in the General Alumni Association by attending the performance. Tickets may be obtained by request from Nathan Winslow, M.D., 608 Professional Building. These are redeemable at the box office at their face value for reserved seats.

## ITEMS

Among those who passed the December examination of the State Board of Medical Examiners for Maryland were Herbert Seth Anderton, class of 1910; Paul Brown, class of 1909; Giuseppe Caturani, class of 1910; William Barber Fellers, class of 1910; Herbert Melvin Foster, class of 1910; Charles Alfred Goettling, Jr., class of 1910; Edmund H. Teeter, class of 1910, and Horace B. Titlow, class of 1908.

Prof. Randolph Winslow is in receipt of the following letter from Michael S. Hanna, class of 1910, of Tanta, Egypt:

Tanta, Egypt, December 18, 1910.

*Dear Professor Winslow:*

Six months have passed since I left Baltimore. I could not see you then for a good-bye, as you were in St. Louis. I sent you a postal from Naples, and this is the second time that I write you.

Am sure you will be glad to hear from your students and know how they are getting along, especially in the line of your branch in the profession. Am glad to tell you that the day before

yesterday I did a splendid operation. It was a peculiar and interesting case. The patient had a terrible-looking hydrocele of 10 years' duration, and recently a lump appeared gradually at about the external abdominal ring, with a slight pain and tenderness on pressure. The scrotum needed only a little length to reach the knee joint, and had a tremendous circumference. I diagnosed the hydrocele from the history, signs and by the hypodermic needle, but the painful swelling about the abdominal ring puzzled me. We thought it might be either an inguinal hernia (scrotal) or a hydrocele of the cord or something else. Anyhow, I decided to operate. I began the operation, assisted by George,\* by making an incision as for inguinal hernia, opened the aponeurosis of the external oblique muscle and after a good search I could find no trace for hernia. I found out that the hydrocele, being so old and under such a great tension, the tunica pushed its way upward and caused the swelling and pain. I then closed the inguinal canal as in the operation for hernia (Bassini), and continued the skin incision down on the scrotum. I dissected the tunica from the other layers and cut it off, leaving a piece to protect the testicle. The tunica was thick, like cartilage. I then closed the wound and sent the patient home. Yesterday I called on him. He had absolutely no fever, and the pulse was 85. Today I called on him again, and found him to be in good condition, with one degree of fever, which, I suppose, is usually due to absorption of the slight oozing. Everything was aseptic in this operation. My office at present is well equipped for any operation.

A few weeks ago I did a radical cure for hydrocele under local anesthesia, but this time I did the operation of turning the tunica inside out (Doyen), and though could not be wholly aseptic, I had healing by first intention, which thing taught me that nature could be trusted a great deal. Four weeks after coming here I operated on a case of osteomyelitis of the tibia of a child 12 years old. I was then both the operator and the anesthetist. I gave the chloroform, and as soon as the boy was under I turned the anesthetic to my office boy and opened the skin, took off all dead tissue with the chisel to the canal and packed the whole thing with iodoform gauze. In 20 days the boy had a perfectly good leg. We do all our work with chloroform. In this connec-

tion I feel it my duty to acknowledge with a great deal of respect, as I always did, the high position that our Alma Mater occupies in education, and to admire our professors and the splendid practical course we had in the hospital. I must also mention here that after conversing with some colleagues who received their education in some of the best schools of the United States, I understood that they did not receive one-fourth as much practical work as we had. Kindly offer my regards to Professor Wood, Professor Shipley, Dr. Coale and the rest. In conclusion, I wish you a most Merry Christmas and a Happy New Year.

Your faithful student,

MICHAEL S. HANNA.

N. B.—I forgot to mention that the testicle was found atrophied.

Dr. Samuel T. R. Revell, class of 1905, and Mrs. Revell, formerly Miss Lettie Terry Jones, class of 1905, University Hospital Training School for Nurses, are receiving congratulations upon the birth of a son.

Mrs. Covington, formerly Miss Nellie Hillard, class of 1905, University Hospital Training School for Nurses, is a patient at the University Hospital:

Dr. William Emrich, class of 1902, and Dr. Hugh Brent, class of 1903, have returned from the headwaters of the Amazon, where they have been engaged in practice. Dr. Emrich will return there in three months' time.

Dr. George L. Wilkins, class of 1870, physician to the Baltimore City Jail, during a visit to the Jail recently stepped aboard the elevator while it was in motion. One of the prisoners, who was standing by, realized Dr. Wilkins' danger and pulled him from the rising elevator. Both fell, the prisoner being unhurt, but Dr. Wilkins sustained painful bruises, for which he is now undergoing treatment.

Dr. Louis W. Armstrong, class of 1900, is located at Breckinridge, Minn., where he is one of the three physicians in charge of the hospital con-

\*George S. Hanna, class of 1901, brother of writer.

ducted by the Franciscan Sisters at that place. He writes most interestingly of the hospital. The same order also conducts St. Mary's Hospital, at Rochester, Minn. When the hospital at Breckinridge was built, five years ago, it had a debt of over \$70,000, which is now almost wiped out. The first building erected was a small frame building, now used as a pest house, the present hospital building having since been erected at a cost of over \$125,000, much of which was contributed. It contains about 60 beds, and the hospital staff consists of three men—Drs. Devine, Meckstroth and Armstrong. The members of the hospital staff are also the county physicians, both for Wilkin county, Minnesota, and Richblood county, North Dakota. Dr. Meckstroth's practice carries with it an appointment as physician and surgeon to the Indian School located at Wahpeton, N. D., this appointment coming from the Government and paying \$600 a year. Wahpeton is a progressive and rapidly-growing city. Both Senators from North Dakota live in Wahpeton. It is quite an educational center, the North Dakota State Science School, the Lutheran Bible School and a Norwegian Seminary and the Indian School formerly mentioned being located there. The members of the staff are also Great Northern Railway surgeons, and have annual passes over the line. They are also surgeons and physicians to the Northern Pacific and Milwaukee roads, with passes and fees. The fees for the Great Northern road alone amount to about \$2000 a year. Wahpeton and Breckinridge are practically one city, having one street-car line for the two.

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Dr. Thomas Dalton Crouch, class of 1910, is located at Statesville, N. C., R. F. D. No. 6.

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Prof. R. Dorsey Coale is in receipt of the following letter from Dr. W. Culbert Lyon, class of 1907:

"Baganga, Mindanao, P. I., October 21, 1910.

"My Dear Professor Coale:

"I am stationed here on the east coast of Mindanao, and am 185 miles from the nearest town (Davao, my recent post), in the heart of the Mandayan tribes. I am the post surgeon (and the only 'Medico' on the entire east coast); also am the military and civil courts, as I am the Sum-

mary Court Officer, and, having been appointed by the Government the Municipal Presidente, am its chief executive officer; try all civil cases and impose the sentence of same. At present I have three prisoners—one Moro and two Visayans—in a log jail.

"I keep very busy, as you can imagine, but it is most interesting to associate (cautiously) with these natives and study their customs.

"I sure am 'the King of the Cocoanut Grove,' and at times 'am lonely,' too, for we are 12,200 miles from Washington. This is the farthest army post from its War Department in the world (via sailing route), and 1100 miles from Manila. We get supplies (canned) once a month from a little gunboat, and have to depend upon our rifles for fresh meat, as game (deer and wild hog) are very plentiful within a short distance, and it is safe to hunt in small parties. Yesterday the little boat Samar arrived, and it sounded just like music to hear her whistle. She brought us mail, too (only two months old), and among which was my copy of THE HOSPITAL BULLETIN. I was pleased to notice in same an extract from my letter to you, written upon arrival in Manila last May, and I could almost imagine myself back in dear old Baltimore as I read the University news. The army is very attractive in many ways, but at times an officer is subjected to considerable isolation, and I may resign later on, for I miss my auto, theaters, etc. We may be ordered out into action at any time, as some of the wild tribes 160 miles from here have been doing things via killing one Spaniard, seven Chinamen and quite a number of Filipinos. A detachment of our battalion stationed in that locality were sent out at once, and encountered them, killing a great many, and if they are forced up this way we are to finish them up, and you can count on us doing it in perfect shape, too. I have 'corns' on my right hip from the chronic habit and post order to wear my 45-cal. Colt constantly, and somewhat different from my professional colleague at Cebu (who sees his patients in his underwear), I attend my cases with the gun on at all times.

"Being the only medical man within 185 miles, it offers great opportunities for professional work, especially in surgery. The first day we landed here (one month ago) I did an amputation all alone shortly after arrival (a native smashed her hand while pounding rice), and which incident won their confidence in me from the start; conse-

quently I have been enjoying a large and profitable practice ever since.

"I have a soldier (Visayan) interpreter, who accompanies me at all times, and is my 'body-guard' as well, for he, too, carries a 45. These islands (especially Mindanao) are not as tame and peaceful as is generally thought by the home people. I am picking up Spanish rapidly. This is my full title now, and with kind regards to you all, I am,

"Very sincerely,

"W. CULBERT LYON,

"Primer Teniente Médico Ejercito, U. S..

"y

"Hon. Presidente de Baganga."

Dr. William Fulford Sappington, class of 1901, of Webster Mills, Pa., was a recent visitor to the University Hospital. Dr. Sappington looks not a day older than in his student years, and greets one with the same unfailing smile and cheery comment which made him such a favorite in those old days.

Dr. Thomas Harris Cannon, class of 1901, was born in Baltimore, Md., May 4, 1878, the son of Thomas J. and Eleanora (Saumenig) Cannon.

He received his education in the public schools of Baltimore and Deichmann's Preparatory School, and then entered the Medical Department of the University of Maryland, graduating with the degree of M.D. in 1901. He took special courses in electro-therapeutics, to which department of medical science he now limits his practice. In 1898 he received an appointment as hospital steward in the United States Army, serving until 1899. He is a member of the Medical and Surgical Faculty of Maryland, the American Medical Association and the University of Maryland Medical Association, and is a fellow of the American Electro-Therapeutic Association. He is surgeon to the Methodist Episcopal Home for the Aged and a member of the Protestant Episcopal Church of the Ascension. Dr. Cannon married on January 18, 1899, Miss Myrtle Evelyn Warner. They reside at 401 North Fulton avenue, Baltimore.

Dr. J. Whitridge Williams, class of 1888, has been appointed dean of the Johns Hopkins Medical School, succeeding Dr. William H. Howell, resigned.

Dr. Arthur Leon Wright, class of 1908, has been appointed pathologist at the Maryland Hospital for the Insane, Catonsville, vice Dr. Robert P. Winterode, resigned.

Dr. Guy Steele, class of 1897, of Cambridge, Md., is ill with pneumonia.

Dr. M. E. B. Owens, class of 1910, a member of the University Hospital staff, left for Spokane, Wash., December 23.

Dr. William D. Hammond, class of 1908, of Hagerstown, Md., has been placed in charge of the Free Skin and Cancer Hospital in St. Louis. This hospital was the gift of George D. Barnard, a St. Louis philanthropist, and cost to erect \$175,000. Dr. Hammond graduated at the Washington County High School before entering the University. After his graduation he was for a time resident physician in the University Hospital, afterwards entering St. Agnes' Hospital, Baltimore.

Dr. Frank C. Heath, class of 1901, is located at Weston, W. Va.

Dr. Herbert Schoenrich (class of 1907) formerly of Canton street, Baltimore, has disposed of his practice there to Dr. Wm. F. Schwartz (also of class of 1907), in order to become assistant to Dr. Sylvan H. Likes, the genito-urinary specialist. Dr. Schoenrich will devote his entire practice to the diseases of the genito-urinary system, the Wassermann reaction and skin diseases, and will be located hereafter with Dr. Likes at 1134 Linden avenue. Dr. Schwartz was located at Bayview for some time.

Dr. James Hugh Bay, class of 1908, has located at Havre de Grace, Md.

A meeting of the General Alumni Association of the University of Maryland for the purpose of selecting a committee to nominate an advisory committee for the alumni council was held at Davidge Hall, Lombard and Greene streets, January 11. The following committee was named: Mr. Walter I. Dawkins, chairman ex-officio; Dr. E. F. Cordell, medical department; Dr. I. H.

Davis, dental department; Mr. Frank V. Rhodes, law department; Dr. J. H. Hancock, pharmacy department, and J. D. Iglehart, department of arts and sciences. The meeting was called by the board of directors and the executive committee of the General Alumni Association. The alumni council will act as an advisory committee between the alumni and the faculty of the University. It is hoped that by so doing the alumni of the University throughout the country will take a greater interest in the work of the University.

Five graduates from each department will be selected by the committee. The 25 names will be submitted at a general meeting January 25, when 20 of those named will be elected as the advisory committee for one year.

### ENGAGEMENTS

The marriage of Dr. John Watkins Williams, class of 1906, of Everetts, N. C., to Miss Bertie Zenobia Gardner, daughter of Mr. and Mrs. Frederick Gardner of Williamston, N. C., will take place on Wednesday, January 18, 1911, at the Methodist Church of Williamston. N. C.

### MARRIAGES

Mr. and Mrs. Thomas Biscoe Gourley announce the marriage of their daughter, Anne Cary, a member of the class of 1911, University Hospital Training School for Nurses, to Dr. James Dawson Reeder, on Friday, December 30, 1910, at "Holland Point," Calvert county, Maryland. Dr. and Mrs. Reeder will be at home after February 1 at 639 North Fulton avenue, Baltimore, Md.

Dr. Reeder was born in Dorchester county, Maryland, July 16, 1879, the son of Charles M. and Katie M. (Dawson) Reeder, of Scotch and English ancestry. He obtained his early education in public and private schools and Deichmann's Preparatory School, Baltimore, in 1897 matriculating at the University of Maryland School of Medicine, graduating in 1901. During his senior year Dr. Reeder was a house student. Since his graduation he has engaged in general practice, and has been assistant demonstrator of histology from 1901 to 1904, and later assistant demonstrator of anatomy and lecturer on osteology, and is at present instructor in proctology. He is a member of the Medical and Chirurgical Faculty of Maryland.

The ceremony was performed at the home of

the bride's parents, the maid of honor being Miss Henrietta Ashcom Gourley, a graduate of the University Hospital Training School for Nurses. The brother of the groom, Mr. Maurice Reeder, was best man. The ceremony was performed by Rev. Benjamin B. Lovett, rector of St. Paul's Protestant Episcopal Church of Prince Frederick, Md. The bride wore a gown of crepe meteor over messaline, trimmed with baby Irish lace and garnitures of pearls. Her only ornament was a diamond cross, an heirloom, the gift of the groom.

### DEATHS

Dr. James H. Harris died at his home, 857 North Eutaw street, Baltimore, Md., December 12, 1910, aged 76 years. Death was due to pneumonia. Dr. Harris was ill but a few days.

Dr. Harris was born in Albemarle county, Virginia, but came to Baltimore shortly after the Civil War. He received his early education at private schools in Virginia, and later became a student in the Baltimore Dental College. He afterwards studied at the College of Physicians and Surgeons.

For many years he was connected with the University of Maryland.

During the Civil War he was connected with the Hospital Corps of the Confederate Army, and took part in practically all of the campaigns in the northern section of the Southern States.

He is survived by the following children: Mrs. J. B. Thomas, Mrs. N. G. Darby, Mrs. Ella M. Steele, Mrs. E. J. Jenkins, Dr. C. C. Harris and Dr. J. E. Harris. He also leaves a brother and sister—Dr. Frank L. Harris and Mrs. Mattie Kent, both of Harrisonburg, Va.

The funeral took place December 14, services being conducted by Rev. Dr. J. Houston Eccleston, pastor of Emmanuel Protestant Episcopal Church.

After the services the body was sent for burial to Harrisonburg, Va., where the dentist spent many of his summers in recent years. Harrisonburg Lodge of Masons, of which he was a member, was in charge of the funeral.

The pallbearers at the home on Hamilton Terrace were physicians and dentists with whom Dr. Harris formerly associated. They were Drs. B. Holly Smith, T. O. Heatwole, Cyrus M. Gingrich, John S. Geiser, I. H. Davis, C. B. Matthews and L. W. Farinholt.

Dr. Harris was a native of Albemarle county,

Virginia, was connected with many of the most prominent families of the Old South and treated numbers of many of the best warriors and statesmen the Confederacy produced. Among them were Mrs. Stonewall Jackson, Mrs. Jefferson Davis and Gen. Robert E. Lee. He was connected by blood relationship with the Dabneys, Ramseys, Overtons and other old Virginia families.

Out of respect to Dr. Harris the medical, pharmaceutical and dental departments of the University of Maryland held no lectures the day of the funeral.

The senior class of the dental department assembled the day of the funeral opposite his residence, and marched in a body to pay their last respects to him.

## BOOK REVIEWS

**PRACTICAL BACTERIOLOGY, BLOOD WORK AND ANIMAL PARASITOLOGY.** Including Bacteriological Keys, Zoological Tables and Explanatory Clinical Notes. By E. R. Stitt, A.B., Ph.G., M.M., Surgeon U. S. Navy; Graduate London School of Tropical Medicine; Associate Professor of Medical Zoology, Philippine Medical School; formerly Instructor in Bacteriology and Tropical Medicine, U. S. Naval Medical School, and Lecturer in Tropical Medicine, Jefferson Medical College. Second Edition, Revised and Enlarged. With 91 illustrations. Philadelphia: P. Blakiston's Son & Co. 1910.

Practical Bacteriology is a superb student's manual. Here is to be found in concrete, condensed, simple language a thorough discussion of bacteriology, including blood work and parasitology. Culture materials, culture characteristics, moulds, diagnosis of fungi, bacteriological examination of milk, the practical aspects of immunity, preparation of vaccines, micrometry, leucocyte counting, preparation and staining of blood films, normal and pathological blood conditions, etc.

Particularly attractive is Part Three, which deals with the various aspects of animal parasitology. Here we find the methods of classification, of nomenclature, hosts, etc. Chapters are devoted to the protozoa, flat worms, round worms, the arachnoids, the insects (pediculidae, diptera, acanthiidae, pulcidae, muscidae, mosquitoes, etc.)

The number of well-executed illustrations lends

additional attractiveness to the book, which is well written, and printed on good paper.

While each subject receives due attention, the contents are not unduly amplified so as to render the volume too burdensome to the student or general practitioner who may go to it for reference. We take great pleasure in recommending it to the student body, and feel they will not regret its acquisition.

**INTERNATIONAL CLINICS.** A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles on Topics of Interest to Students and Medical Practitioners. By Leading Members of the Medical Profession Throughout the World. Edited by Henry W. Cattell A.M., M.D., Philadelphia. Volume IV. Twentieth Series, 1910. Philadelphia and London: J. B. Lippincott Company. 1910.

Among the best of the many good articles contained within the volume is Ehrlich's New Preparation, Arsenobenzol ("606"), in the treatment of syphilis, by Henry W. Cattell, whose conclusions are as follows: That in properly selected cases this method outweighs the older methods of using mercury internally, or by inunctions, fumigations, or injections; that the attendant dangers are no greater than in the hypodermic use of the insoluble salts of mercury; that the discovery of this remedy demonstrates what may be obtained by painstaking research. De Schweinitz and Shumway report the effect of a single injection of "606" in a case of syphilitic iritis as being of undoubted benefit, the lesion quickly subsiding and sight restored. In this case no mercurial treatment had been employed previous to the injection of "606," with the exception of several inunctions of blue ointment. The report is of interest in so far as it aptly illustrates the wide and favorable use of this new remedy. Hirshfelder's article throws much light on the tests for the functional efficiency of the heart. Dorrance and Ginsburg have a very interesting article on a method of transfusion of blood employing only veins. Their method was evolved as a substitute for the artery to vein method, which is both difficult and dangerous, cases of acute dilatation of the heart having occurred both in their and other hands as a result of the employment of the above mentioned technic. In the vein to vein method the

superficial veins are employed, rendering the method simple and easy of performance, and the danger of acute dilatation of the heart is obviated. The article concludes with a complete resume of the technic and a report of eighteen cases in which the method was employed. Eisen-drath's lecture on the Retrocecal Appendix is very instructive and well worth reading. It is extremely difficult to select an article for especial mention from such an array of meritorious articles and dignify it with the name of best. As a matter of fact, the reviewer has merely scratched the soil, and owing to a lack of space must forego a further enumeration of those articles which are worthy of individual mention. The latest work in medicine, surgery, neurology, pathology, ophthalmology and state medicine are here recorded in a space sufficiently contracted as to enable the busiest man to familiarize himself with the latest developments in his specialty without infringing too greatly on his time. This volume is one of if not the best of the series issued by Lippincott's.

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**LESSONS ON THE EYE.** For the Use of Under-graduate Students. By Frank L. Henderson, M.D.; ex-President of the St. Louis Medical Society (1905); Chairman of the Ophthalmic Section of the St. Louis Medical Society (1910); Ophthalmic Surgeon to St. Mary's Infirmary; Consulting Oculist to the Wabash Railway; Member of the American Medical Association; Member of the Missouri State Medical Association; Member of the American Academy of Ophthalmology and Otolaryngology, etc. Fourth edition; revised. \$1.50 net, cloth. Philadelphia: P. Blakiston's Son & Co. 1910.

As a foreword the reviewer notes that the book has been entirely revised, so as to make the subject-matter conform to knowledge of the present time. Its usefulness rests not on its value as a textbook, but as an auxiliary to classroom lectures. It is adapted to this purpose excellently, and by its thorough revision is more than ever an acceptable adjunct to both lectures and larger textbooks. Present books on ophthalmology seem to indicate the present ideas of teachers on this subject that they should speak the last word. Students certainly cannot be made specialists in this branch of medicine, or, in fact, any other

branch, and the sooner writers and teachers realize this fact the better. In the limited time at the disposal of students only the elements of ophthalmology can be acquired, and a book which is based on this knowledge is greatly to be appreciated. Such a book is Henderson's. Although it treats the subject in a rather sketchy manner, still, in our judgment, it contains a sufficiency for the purpose, and is excellently adapted to the needs of those for whom it is intended.

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#### SOME POSOLOGICAL HINTS AND OTHER USEFUL INFORMATION. The Fellows Company.

Posological Hints is a little pamphlet issued by the Fellows Company which contains among other information a table of incompatibilities, the dosage of the more important drugs, a table of the cathartics and purgatives, the diuretic agents, a diet table for tubercular patients, etc.

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**CARE OF THE PATIENT.** A Book for Nurses. By Alfred T. Hawes, A.M., M.D. With six illustrations. Philadelphia: P. Blakiston's Son & Co. 1911. Cloth, \$1 net.

The above-mentioned volume is devoted to the part the nurse plays in the management of the sick. Her field is just as important as that of the physician, surgeon or obstetrician; consequently, it is incumbent on a thoroughly conscientious nurse to so perfect herself in the details of her profession that she almost automatically does the right thing at the right time. Her technic must be as complete as that of the medical man if there is to be a successful issue. This little book of some 160 pages admirably meets the demands of those nurses who are looking for practical suggestions in the field of medical, surgical or obstetrical nursing. The bath, care of the mouth, care of the skin, care of the teeth, feeding the patient, waking the patient, administration of medicine, hypodermic medication, the various forms of bath, both hot and cold, the proper method of handling defects, the preparation of a patient for operation, post-operative management, some words of wisdom on maternity nursing (before confinement, during and after). The book is well written and full of helpful suggestions, but does not devote sufficient space to any subject to make its field of usefulness more than an adjunct to lectures. It is in this field or as a quick reference book that it will be found most adapted to those for whom it is written.

# THE HOSPITAL BULLETIN

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No. 12

## A CASE OF GASTRIC HYPERACIDITY.

By HARRY J. TANKIN and L. H. DOUGLAS,  
*Senior Medical Students.*  
*Candidates in Medicine.*

From the Clinic of John C. Hemmeter, M.D.,  
LL.D., Ph.D., etc., Professor of Physiology  
and Clinical Medicine, University of Maryland.

Name, C. K.; age, 55; race, German; occupation, laborer; social condition, married.

*Diagnosis.*—Gastric hyperacidity, with probably a gastric ulcer, complicated by diarrhea.

*Family History.*—Father died 38 years ago of tuberculosis. Mother died 31 years ago of Bright's disease. Three sisters dead; cause unknown. One brother died of heart disease and one killed in an accident. There is no history of malignancy in the family.

*Past History.*—Patient had measles at four years of age, and rheumatism at 34. The history is otherwise negative. Patient denies venereal disease. The personal history is negative to tuberculosis.

*History of Present Illness.*—Patient complains of severe pain in left hypochondriac region, almost constant, stabbing in character, and relieved by eating. He has limited himself to the following diet: Eggs (soft-boiled), bread, fruit (no apples), and milk, of which he drinks large amounts and which relieves his pain. He has a sense of fullness in the stomach continually; no burning in epigastrium; his appetite is fair; eructates frequently, which eructation has a sour taste; sleeps poorly; has no headache and no nervousness. Complains of pain being worse when his stomach is empty, which is relieved by eating or drinking milk. There is neither nausea nor vomiting on either an empty or a full stomach, although when much pain is present he induces

vomiting by irritating his throat with his fingers. There is rather a marked diarrhea, patient having five or more movements daily.

There are no pulmonary symptoms, no circulatory symptoms or urinary symptoms.

*Physical Examination.*—Patient is an extremely well-nourished individual. The hair, eyes and ears show nothing. Argyle-Robinson pupil absent. Nose shows nothing abnormal. Teeth are worn down almost to the gums. Tongue shows nothing abnormal; pharyngeal walls normal. Neck, chest, heart and lungs are all in good condition by auscultation and percussion.

*Abdomen.*—Stomach on percussion shows slight degree of dilatation. Liver, kidneys and spleen are all normal. No floating tenth ribs palpable. Abdomen shows an enormous amount of fat.

### Measurements.—

Manubrium to xiphoid, 9 inches.

Manubrium to umbilicus, 17 inches.

Manubrium to symphysis pubis, 22 inches.

Xiphoid to right superior spine, 11 inches.

Xiphoid to left superior spine, 11 inches.

Spine to spine, 9.5 inches.

Circumference at xiphoid, 44 inches.

Costal angle, 90°.

*Examination of Urine.*—Albumen negative, sugar negative and blood negative, S. G. 1024.

*Examination of Feces.*—Fluid in content, markedly foul in odor, color greenish, showing many bile-stained particles and fat droplets. No blood was found. There were no worms present or evidence of any, as evinced by ova.

*Examination of Stomach Contents.*—A test meal was taken at 11.30 A. M., consisting of a piece of dry bread and two glasses of water. The contents were withdrawn at 12.30 P. M., and showed the following: About four ounces of a yellowish, flocculent matter, extremely acid to reaction, showing carbohydrate food particles taken four hours previously and only slightly acted upon. This would indicate atony of the stomach.

The filtrate gave upon titration free hydrochloric acid 70, and total acidity 90.

From the above we have concluded the patient to be suffering from an enormous hyperchlorhydria and probably a gastric ulcer. We would, to summarize, base our diagnosis upon the following reasons:

First. He has intense, almost constant pains on empty stomach, which are relieved by taking food, and are intensified by any acid food. The pains, however, are not reflected to the back, and are located farther to the left and lower down than is usually the case in ulcer of the stomach, or in hyperacidity, either.

Second. The history of intensely acid eructations of gastric contents, the reality of which is shown by the eroded teeth, and is a diagnostic point of no little importance.

Third. A persistent diarrhea, which shows carbohydrate food particles poorly digested, and which have been hastened along to the rectum from increased peristalsis, due to the stimulation of an excessively acid stomach contents acting on the intestines. The diarrhea is due to a colitis.

Fourth. The examination of his stomach contents showed no blood.

A possible obstruction at the pylorus is suggested, although examination did not reveal a greatly distended stomach.

As confirmatory evidence in regard to the gastric ulcer, an X-ray picture should be made in accordance with the general directions laid down in an article in the *Journal of the American Medical Association* for November 12, 1910. This article was published by Dr. Harry Adler, who states that he received his first stimulus in this connection from Dr. John C. Hemmeter.

*Treatment.*—First relieve this hyperacidity. This can be done by some such treatment as the following:

Magnesii Usti,	10.0
Sodii Bicarb.,	10.0
Pulv. Rad. Rhei,	5.0
Ext. Belladonna,	0.3

Sig. One-half teaspoonful three-quarters of an hour after meals, or

R	Sodii Bicarb.
Potass. Carb.	
Magnes. Usti,	5.0
Ext. Belladonna,	0.25
Sacch. Lactis,	20.0

Sig. One teaspoonful one hour after meals.

First. Starvation treatment, or as great rest as possible, should be given the stomach, returning gradually to a stronger diet, with milk as a starter. (The patient is extremely well nourished and could well stand starving.)

Second. For the ulcer, if present, bismuth subnitrate should be given by lavage, to act as a mechanical covering.

Third. There is a possibility that this is a neurosis, and the pains are due only to an excess of free hydrochloric acid acting on a very sensitive mucous membrane.

Fourth. If this were a neurosis, electricity, hydrotherapy, lavage, bromides and strychnia sulphate might be of benefit.

Fifth. For his diarrhea it requires lavage of the colon by tannic acid 1 part to 1000.

#### A CASE OF GASTRALGIA.

By B. S. BOYER and M. L. BAREFOOT,  
*Senior Medical Students.*

*From the Clinic of Dr. John C. Hemmeter, M.D., Ph.D., LL.D., etc., Professor of Physiology and Clinical Medicine, University of Maryland.*

As a rule, the general practitioner attaches very little importance to pain in the epigastric region. Usually the patient is told that he has a colic and some anodyne mixture containing in too many cases morphine or chloroform is prescribed.

In this present case there is an example of a complicated symptomatology, which at times suggested cholelithiasis, at other times pancreatitis, at still others colitis and the accompanying colic pain. Then there were indications that suggested gastric ulcer, and eventually we had to eliminate the possibility of locomotor ataxia, for the pains gave some similarity to the "crises" of tabes dorsalis.

Name, Mrs. H. C.; color, white; age, 47; social condition, married; nationality, American; occupation, housewife.

*Diagnosis.*—Gastralgia.

*Complaint.*—Pain in the stomach.

*Family History.*—Father and mother died of old age, direct cause unknown; otherwise, family history is negative. Gives negative history of any malignant disease in family, as tuberculosis, cancer, epilepsy or paresis, lies negative.

*Past History.*—Had scarlet fever in infancy; all other diseases, as typhoid, diphtheria, pneumonia, pleurisy, rheumatism, etc., negative.

*Present Illness.*—For past 12 years patient has been complaining of pain in the epigastrium transmitted to lumbar region, which is of a transitory nature, usually coming on after meals, and at other times lasting an hour or so and then gradually fading away. Complains also of pain in right iliac region, especially on certain movements of the body, which are dull and aching in character, but not sensitive to pressure. Complains of tingling and numbness in right fingers. Ankles are non-edematous. No burning in epigastrium, no anorexia, some headache and nervousness at times. Experiences a fullness of weight after meals, with some pain. Superficial pressure over the epigastrium gives temporary relief, but deeper pressure augments the pain. Eruptions present and *decided distension* of stomach. Sleeps fairly well, but not sound. On empty stomach at various intervals has pain in right side, being more or less localized in the iliac region. Nausea and vomiting present on full stomach, but occurring infrequently, usually giving temporary relief. No bile or blood present in vomit, but has a foul taste, food particles and mucus being present. Appetite fair; drinks little water, but large amount of coffee. Always eats a little lunch before retiring, as this appears to eradicate her pain at night. Bowels slightly constipated, requiring laxatives off and on. Reflexes at times absent at patella.

*Genito-urinary Tract.*—Negative.

*Menstrual Disorders.*—Negative.

*Fistula and Piles.*—Negative.

*Physical Examination.*—Head, thorax, heart and lungs negative. Oral cavity in fair condition. Tongue slightly coated, and artificial teeth being required to masticate her food. Abdomen much distended, and outlines of stomach extend several inches below umbilicus. No emaciation or recent loss of weight. Kidney and spleen not palpable. Liver area normal; no floating of tenth ribs. Test

meal obtained September 3, and free hydrochloric acid 20 was found; total acidity 60. Also a test meal obtained October 19, in which free hydrochloric acid was 18. Lactic acid absent and bromine water test negative. Temperature 99°. Height 5 feet 2 inches. Weight 136 pounds. The examination of feces and urine were negative.

*Measurements.*—M.—X., 7½ cm.

M.—U., 12½ cm.

M.—S., 19 cm.

X.—R. S., 10 cm.

X.—L. S., 10 cm.

S.—S., 9¼ cm.

Cir. at X., 31 cm.

Angle at X., 75°.

The diagnosis of gastralgia is not a typical one, but it simulates that more than any other condition, as its chronic duration, no loss of weight, bowels constipated, headache, eructations, vomiting, pain on empty stomach relieved by food or by pressure over that region, and by the efficacious results of symptomatic treatment. Diagnosis from cancer of the stomach by its chronicity, no emaciation, anemia, anorexia and presence of *free hydrochloric acid 18-20*. In the tabic crises we meet with the Romberg sign—the belt sensation and the characteristic gait.

*Treatment.*—Abdominal massage and galvanic current, using not less than 25 milliamperes, having the plates moistened and the anode placed over the epigastrium and the cathode on the spinal column. Suggested supporting bandage being a probable benefit. Although the stomach is distended, there is no apparent atony present. Hot applications to abdomen during pains might give good results.

*Dietetic.*—Advised to discontinue use of coffee, or else use it moderately. Eat about what she wishes, but to masticate it thoroughly, and eat less at a time and more often during the day. A cup of hot water sipped before meals might give beneficial results. Lavage could not be instituted in this case, and since there was no apparent real gastric or atonic condition, and on account of patient's inability to be present for treatment, it was not insisted on.

*Medicinal.*—Strychnine sulphate and bromides given; lapactic pills administered before retiring for chronic constipation. The above treatment appeared to benefit patient greatly, the bromides acting as a sedative and relieving the pain.

NASHVILLE, AND THE MEETING OF  
THE SOUTHERN SURGICAL AND  
GYNECOLOGICAL ASSOCIATION.

By RANDOLPH WINSLOW.

The twenty-third annual session of the Southern Surgical and Gynecological Association was held at Nashville, Tenn., on December 13, 14 and 15, 1910. The papers were numerous, and in most cases of exceptional interest. The members in attendance were from widely-separated regions, but the greater number were from the 11 Southern States. Amongst the celebrities present were Maurice Richardson of Boston, Robert T. Morris and W. B. Coley of New York, Rudolph Matas

was chilly, and a heavy overcoat was comfortable. Nashville is the capital of Tennessee, and has a population of 112,000, according to the last census. As is the case everywhere in the South, the old regime is passing away and a new one is at hand. The fine old-fashioned residences in Nashville are being torn down to make room for modern fireproof buildings of many stories, whilst new, and in many instances, magnificent homes have been built in the suburbs. The atmosphere of Nashville at this time of the year is not only chilly, but is filled with smoke from factories and railroads to such an extent as almost to rival Pittsburgh, and one can only keep reasonably clean through many ablutions and changes of linen; but if the outward conditions are as described,



PRESIDENT JACKSON'S HOME IN NASHVILLE.

of New Orleans, Alexander Hugh Ferguson of Chicago, Howard A. Kelly of Baltimore, Lewis S. McMurtry of Louisville and Roswell Park of Buffalo.

In company with my friend, and former companion in many miles of travel in this country and in Europe, Dr. J. Mason Hundley, I left Baltimore on December 11, at 5 P. M., on the Pennsylvania Railroad, and when we arose the next morning we were at Columbus, O. From there to Cincinnati, where we crossed the Ohio river, and thence through Kentucky to Louisville; an additional run of some hours brought us to Nashville, and a rickety hack, driven by a dilapidated negro, landed us at the Hotel Hermitage, a brand-new and up-to-date hostelry. The hills and dales of Maryland were clad in a deep coat of snow, but at Nashville there was no snow, though the air

hospitality is not only warm and agreeable, but is displayed in great prodigality. The physicians of the city and their ladies exerted themselves without stint to render the occasion of the session memorable. By far the most noteworthy and interesting of the several entertainments given in honor of the meeting was an automobile excursion to the Hermitage, Andrew Jackson's home, about 12 miles from the city. The original large estate has been much reduced in area, but the house and a considerable acreage of land is now owned by an association of patriotic ladies, who have restored the property to its former appearance. The house is approached by a long avenue, lined on both sides with tall cedar trees planted by General Jackson himself. The grassplot in front of the house is shaped like a guitar, the avenue above mentioned being the handle of the instrument.

The home is of the late colonial style of architecture—a large two-story brick building with six stone pillars reaching from the ground to the roof, and with both a lower and upper portico. At each end of the portico are two wings, formerly

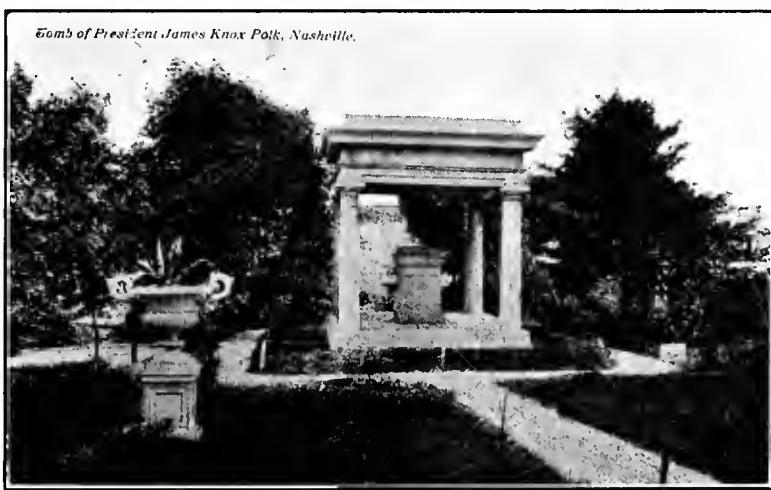
erection of the handsome new home, and on the grounds is the cabin of "Uncle Alfred," General Jackson's negro body servant, who lived to be 95 years of age and died within a few years. He is buried near the tomb of his master, and upon his



HERMITAGE ENTRANCE, HOME OF ANDREW JACKSON.

used as a dining-room and office, respectively. The interior of the house is preserved as nearly as possible in the same condition it was in when its distinguished owner left it. Most of the original furniture has been replaced; even the bedding and bed clothes are the same. Mementoes of Jackson of various kinds have been preserved; letters and books, uniforms and weapons, portraits and bric-

tombstone is inscribed "Uncle Alfred, faithful servant of Andrew Jackson." It is reported that upon one occasion he was asked if he thought the General had gone to heaven, and he replied, "Sar-tain." When asked why he thought so, he answered, "I likes to know whose gwine to keep him out if he wanted to go dar." The General is buried beside his beloved and devoted wife, under



TOMB OF PRESIDENT POLK.

a-brac. In an outbuilding is the ancient carriage in which the General used to make his journeys to and from Washington, which required 30 days each way. Within sight of the Hermitage is the little log cabin in which he lived previous to the

a handsome marble mausoleum, in the garden of the Hermitage, where are gathered also the remains of many members of his family.

Another President of the United States is buried at Nashville—James K. Polk—whose

tomb, with that of his wife, is located on the grounds of the Capitol. The Capitol is a massive granite building of rather gloomy aspect within and without, and is situated on an eminence overlooking the city. Nashville was the scene of stirring events during the Civil War, and much hard fighting was done around the city when General Hood locked horns with General Thomas and was defeated and driven back.

To revert to surgical matters, Dr. Howard A. Kelly exhibited a series of magnificent photographs of the various steps in the operation of suprapubic cystotomy by a transverse or slightly curved incision, which he thought presented many advantages over the usual method.

Dr. J. Garland Sherrill of Louisville presented the report of a case of ligation of the first portion of the left subclavian artery for aneurism, by means of an osteoplastic resection of several ribs. The ligature was placed on the left subclavian near its origin from the aorta, but it was then discovered that the aneurism arose from the aorta and not from the subclavian. The ligature was then removed, and the man did not suffer any ill-effect from the procedure, but died some while later from rupture of the aneurism.

Dr. John R. Wathen, also of Louisville, presented an illustrated lecture on "An Improved Technique in Goitre Operation." He uses scissors in making his external incision and dissection, and grasps the gland with strong vulsellum forceps, thus drawing it forward and making its enucleation much easier and less bloody.

Dr. Maurice Richardson advocated omentopexy for cirrhosis of the liver, and related several cases in which excellent results were obtained.

Dr. Rudolph Matas advocated using the common bile duct as a route for introducing salt solution into the intestine in cases of biliary toxemia.

Dr. Alexander Hugh Ferguson told how to make new vaginas by using the labia minora and skin flaps from the thighs for lining the artificial canal. The patients were satisfied, the husbands did not complain and the method is commended.

Cancer was considered by Drs. W. B. Coley and Roswell Park, and the causal relationship between injury and cancer was emphasized, as well as the belief that some form of germ was at the bottom of the malady.

Many other papers of great interest were read, and many excellent discussions were elicited. The session was rather remarkable for the number of

papers with lantern-slide illustrations, which certainly added much to their interest.

The present writer had the honor of closing the session with a paper on "Concussion of the Spinal Cord from Gunshot Injury," with the report of two cases of complete transverse destruction of the cord without any direct impact. The next meeting will be held in Washington, D. C., under the presidency of Dr. Rudolph Matas.

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#### THE CENTRAL UNIVERSITY OF QUITO, ECUADOR.

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By ANGEL VIRGILIO AVILES, Ph.B.,  
*Senior Medical Student, University of Maryland.*

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The Central University of Quito, Ecuador, was founded by the Government a half century ago, with power of giving degrees after a six-years' course in medicine and law. Ten years later the department of pharmacy was founded, and after a four-years' course gives a degree of doctor of pharmacy. To this department was added a three-years' course for women, which gives them a degree to take care of a drug store under the direction of a doctor in pharmacy. Also to the medical department was added a course for women, which gives a degree of midwife after a three-years' course.

About 15 years ago a department of arts and sciences and chemistry was added, which gives a degree of chemist and D.S. The authorities of the university are a provost, and deans for each department, with his secretary and professors. The faculty of each department is formed of the provost, dean and three professors, with a secretary.

The system of instruction of the medical department is as follows:

**First Year.** Anatomy, histology, inorganic chemistry with laboratory work, and dissection of the whole body.

**Second Year.** Physiology, organic chemistry, physiological chemistry and bacteriology.

**Third Year.** Internal medicine or practice of medicine, pharmacy, preliminary notions in therapeutics, and physical diagnosis.

**Fourth Year.** External medicine or surgery, medical clinics at the hospital, therapeutics and obstetrics.

**Fifth Year.** Clinics in medicine and surgery at the hospital, applied anatomy, gynecology, ther-

apeutics, practical work at the Maternity Hospital, and children's diseases.

Sixth Year. Review of medicine and surgery, therapeutics, obstetrical clinics, medical jurisprudence, and notions in dermatology and ophthalmology.

At the end of each year the student has to take oral examinations on every subject, during a half hour, before a committee of three professors, being necessarily one of these the professor of the subject in which the student is being examined. After the examinations the student is qualified with the following marks: Best III, and so on, 111, 112, 122, 222, 223, 333, 334 (passing mark), 344 (can take re-examination in October) and 444 (has to repeat the year).

After passing satisfactorily all the subjects already mentioned, he has to take an oral examination before a committee of seven professors, presided over by the dean and provost, during at least two hours, after which he gets a degree of M.D. After this he must also take an examination of an hour, after which he gets admitted or incorporated into the Faculty of Physicians and Surgeons.

The buildings are situated on one of the corners of the square called "Independence Square" (*Plaza de la Independencia*). It occupies an area of two blocks, which is divided in several sections and occupied as follows: Two libraries, one public and one to the university; three museums, one zoological, archaeological and arts and sciences, besides the lecture-rooms and laboratories.

In the center are two gardens, with fountains, occupied by the students as a campus. The hospital, with the amphitheater, is situated two blocks from the university, and is divided into two sections, one for male and one for female patients. Each section is subdivided into four wards—surgical, medical, obstetrical and venereal.

The Dispensary is attended by the students in the morning.

The Astronomical Observatory and the Botanical Garden, situated in a park called "Alameda," are loaned to the students of the university for the benefit of the young men who are interested in the subjects.

Among the authorities should be named:

Dr. Guillermo Ordoñez, anatomy and medicine.  
Dr. Ezequiel Zevallos, physiology and surgery.  
Dr. Mario de la Torre, surgery.

Drs. N. Ortiz and Izidro Ayora, obstetrics and gynecology.

Dr. N. Troya, ophthalmology.

Dr. Mariano Benaherrera, nervous diseases.

Dr. Angel R. Saenz, venereal diseases.

NOTE.—Mr. Aviles attended his first two years at the Central University of Quito and his third year at the University of Pennsylvania. His description of the course of instruction at the distant South American school is therefore from personal knowledge. The curriculum is practically the same as that of the American medical schools, but is spread over six years. According to the data of Mr. Aviles, the University at Quito started as a medical and law school and gradually added other departments, in these respects resembling very closely the University of Maryland.—EDITOR.

#### UNDESCENDED TESTICLE.

By P. P. McCAIN, '11,  
*Senior Medical Student, University of Maryland.*

On November 11, 1910, the following case entered University Hospital for operation on a right inguinal hernia with an undescended testicle.

J. M., age 20 years, has a swelling in the right groin, which recedes when he lies down and reappears when he stands up. He has been having considerable pain and discomfort of late, and he seeks to be rid of his malady.

In addition to the hernia, there is a pigeon-egg-sized body located at the external ring, which is evidently an undescended and poorly developed testicle. The right scrotal sac is empty, while the left compartment is filled with a well-developed and normal testicle.

After the usual preparation the patient was etherized, and was operated on by Prof. Randolph Winslow for the radical cure of the hernia and the placement of the testicle in the scrotal sac. The Ferguson operation for hernia was performed, but the chief point of interest in the case was the treatment of the misplaced testicle.

After the exposure of the sac the peritoneal pouch was severed in such a manner as to make a tunica vaginalis for the testicle, whilst the rest of the pouch was separated from the cord until far above the internal abdominal ring, when it was

ligated and cut off. The vessels of the cord were mostly doubly ligated and divided, leaving only a few vessels with the vas deferens. A pouch was made by blunt dissection in the scrotum and the testicle was placed therein, where it lay easily. A purse-string suture was placed at the neck of the scrotum to prevent the testicle from leaving its new habitat. The inguinal canal was repaired in the usual manner. The subsequent history of the case is unimportant.

In one out of about every 500 male individuals the testicle on one or both sides fails to descend from the abdominal cavity into the scrotum. There are four types of undescended testicle: (1) Where it is in the abdomen, near its original position, just below and in front of the kidney and behind the peritoneum; (2) where it is at the internal ring; (3) where it is in the inguinal canal; (4) where it is external to the external ring. The testicle may also be misplaced into the perineum, or on the thigh through the crural canal. An undescended testicle is a serious condition, and has not in the past received its due amount of attention. It is a more serious condition than an ordinary inguinal hernia. The dangers are as follows: (1) The coexisting hernia, or the increased liability to hernia; (2) the tendency to serious lesions—epididymitis, atrophy and twisting of the cord, with resulting gangrene, etc.; (3) injuries from its exposed position from external violence or muscular exertion; (4) the possibility of malignant degeneration; (5) worry and mental depression resulting from the deformity.

In 1881 Max Schueller devised the first successful operative treatment for this condition. His method consisted in the transverse division of the vaginal process and the stitching of the testicle into the scrotum. The best operation at present, and one followed by splendid results, is that of Arthur Dean Bevan. It is briefly described as follows:

Make a three-inch incision over the inguinal canal through the skin, superficial fascia and the aponeurosis of the external oblique. This exposes a peritoneal pouch, covered with the cremasteric muscle and fascia, and the transversalis fascia, extending from the peritoneum of the abdominal cavity to the scrotum. These thin coverings are divided and the pouch opened. Divide the vaginal process of peritoneum transversely well above the testicle, being careful not to injure the cord. Close the upper end, as in a hernia op-

eration, with a catgut ligature and the lower end with a purse-string suture, thus making a tunica vaginalis for the testicle. Then with a gauze sponge carefully wipe the peritoneum from the cord. This process lengthens the cord. Either with the fingers or with blunt dissecting forceps tear away any tense fibrous strands in the cord. If, as occasionally happens, there extends a peritoneal pouch to the bottom of the scrotum, push the testicle into it and retain it there by a purse-string suture around the neck of the scrotum. Usually this pouch is not present, and it is necessary to make one in the scrotum by blunt dissection with the finger. If the cord is too short, divide the spermatic vessels between ligatures and make gentle traction upon the cord till the testicle can be placed in the scrotum and kept there without tension upon the cord. It has been found that the artery and vein of the vas are quite sufficient to supply the entire testicle.

Now close the wound as in a hernia operation, not transplanting the cord, but keeping it in its original position.

The success of this operation depends upon freeing the testicle so completely that it can be placed in a roomy pocket well down in the scrotum without tension. Of the 34 cases operated on by Dr. Bevan, 30 have been entirely cured. By this method even testicles within the abdominal cavity can be brought down and retained in the scrotum.

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Dr. Arthur L. Wright, class of 1908, who recently became pathologist at the Maryland Hospital for the Insane, near Catonsville, has resigned and has accepted a place on the medical staff of the Baltimore & Ohio Railroad. Dr. Wright has been at the hospital for some time. About six weeks ago he was appointed pathologist to fill the vacancy created by the resignation of Dr. R. P. Winterode, who was appointed superintendent of the new Hospital for the Negro Insane. Dr. J. Percy Wade is superintendent of the Maryland Hospital for the Insane, and Dr. Robert Edward Garrett, class of 1890, is assistant.

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We are glad to report to the friends of Dr. Guy Steele, class of 1897, of Cambridge, Md., that he has recovered from his attack of pneumonia and has resumed his practice.

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NATHAN WINSLOW, M.D., Editor

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BALTIMORE, MD., FEBRUARY 15, 1911.

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## THE BOARD OF INSTRUCTION.

At a meeting of the Faculty of Physic of the University of Maryland, held June 28, 1910, the following resolution was introduced and adopted:

*Resolved*, That hereafter faculty meetings of two kinds be held. First, of those who are regents of the University, to be known as the 'Faculty,' and second, of all those actively engaged in teaching, who are to be known as the 'Board of Instruction.' The meetings of these bodies to be held on the first Tuesday of alternate months. The Board of Instruction to include the Faculty of Physic and the following instructors, viz: Professors Hirsh, Woods, Fulton, Base and Cordell; Clinical Professors Hundley, Gilchrist, Martin, Spruill, Taylor, John Winslow, Craighill, Graham, McElfresh, Spear and Adler; Associate Professors Smith, Jay, Wilson, Holland and Timberlake."

It includes all who hold the rank of professor, clinical professor and associate professor.

The creation of this board was prompted by a desire to accomplish several results.

It had been felt for some time that all of the men doing the teaching in the different branches of the medical department should have more voice in the management of the curriculum. Indeed, an important step in this direction had been taken several years ago when the adjunct faculty was organized, and last year a committee of the adjunct faculty did a large amount of work in drawing up and recommending sweeping changes in the medical curriculum. Their report was referred to a joint committee, and after some minor changes the reported curriculum was adopted.

Another thing aimed at in the creation of this board was to give the teaching staff as a body a maximum of information regarding the work and fitness for advancement of the individual student. The men composing this board are in close association with the student body and represent a sum total of knowledge regarding a student's fitness for graduation that is of the greatest usefulness.

Another object was to draw together into closer relationship all of the men at the heads of the different departments, so that they would come to appreciate each other's difficulties, and accordingly make their criticisms constructive in character. This board, which has been in existence less than a year, has already more than justified its creation. In the first place, it worked out the new curriculum for the first fifteen weeks in the only satisfactory way that it can be worked out—that is by taking up each year's work separately and putting the schedule on the blackboard. This can be done in a satisfactory manner only when all of the heads of departments are present, so that each man may be able to look after his own branch. This year's change in curriculum has been most gratifying in results thus far. There is a large freshman class, and for the first time in years the freshman class is very busy. The freshmen and sophomores are entirely separated, and there has been an almost total lack of the usual bench-breaking and noisy class fights seen in other years.

At the last meeting of the board a committee was appointed to recommend changes in the grouping of the different subjects in order to make the grouping less open to criticism. The committee has completed its work and is ready to report at this month's meeting.

One serious word should be said to the men composing the board, and that is in regard to attendance. It is the earnest hope that the board shall take over and manage everything that pertains to the teaching of medicine at the University. A man is of value on any board directly as the result of two things. First, his ability, and second, his particular knowledge of the thing at hand. This particular knowledge can only be acquired by constant attendance on board meetings. There is a big opportunity to do good work. Let us do it.

At the next meeting to be held this month a number of important things are to be considered

and decided. Most important, however, is the arranging of the work for the second fifteen weeks for all four years. Each man should be present in order to look out for himself; to see that he gets the number of hours he needs and the particular hours which are best suited to him, to his class and to the subject taught.

## SOCIETY REPORT

### THE ALUMNI ADVISORY COUNCIL AND ITS MEMBERS.

A special meeting of the General Alumni Association was held Wednesday, January 25, 1911, at 8:15 P. M., in Davidge Hall for the purpose of receiving the report of the Committee on Nomination for the Alumni Council, and to reconsider, if deemed wise, the plan under which the Council will act. The meeting was called to order at 8:30 P. M. with Walter I. Dawkins, the president, in the chair. It was duly moved, seconded and passed that the Committee on Nomination make their report. The report was accepted, but was amended to this effect, that the nomination of the proposed members of the first Alumni Council be made in open meeting. It was moved, seconded and passed that the Tentative Plan for Organization of an Alumni Council of the University of Maryland, as adopted November 11, 1910, be reconsidered. A substitute plan was then offered by Dr. E. F. Cordell, viz:

"In view of the need of closer co-operation between the Alumni and Regents of the University for the promotion of the interests of the institution,

*Resolved*, That the General Alumni Association hereby creates an Advisory Alumni Council, which shall be organized and administered as follows:

"1. It shall consist of twenty members of this Association, to be elected at the annual meeting on open nomination.

"2. The members shall hold office for one year.

"3. The membership of the Council shall be equally divided among the five departments of the University, four from each department.

"4. The Council shall be called together by the secretary of this Association as soon after its election as possible.

"5. It shall organize by electing its own officers for the year and adopting its own rules of government, due regard being had to the objects of its creation.

"6. The first members of the Council shall be elected tonight and shall hold office until the next annual meeting.

"7. Vacancies in the Council shall be filled for the unexpired term by appointment of the president of this Association."

Doctor Cordell moved that the plan be adopted as read, which motion was duly seconded. Each section of the plan was thoroughly discussed by those present, and the following plan was finally evolved and adopted as a whole:

### ADVISORY ALUMNI COUNCIL.

PLAN ADOPTED BY GENERAL ALUMNI ASSOCIATION,  
JANUARY 25, 1911.

"In view of the need of closer co-operation between the Alumni and Regents of the University for the promotion of the interests of the institution,

*Resolved*, That the General Alumni Association hereby creates an Advisory Alumni Council, which shall be organized and administered as follows:

"1. It shall consist of thirty Alumni of the University, not Regents, to be elected at the annual meetings.

"2. Nomination of members of the Council shall be made by a committee of five, one from each department, which committee shall be appointed by the president of the Association at least thirty days before the annual meeting. This shall not preclude nominations in open meeting.

"3. Of those members first selected, as above provided, fifteen shall hold office for one year and fifteen for two years, the tenure of office to be determined by lot at the first meeting of the Council. So that, at the end of the first year and each succeeding year thereafter, fifteen members shall be elected to serve for two years.

"4. The membership of the Council shall be equally divided among the five departments of the University, six from each department.

"5. The Council shall be called together by the secretary of the Association as soon after its election as possible.

"6. It shall organize by electing its own officers for the year and adopting its own rules of

government, due regard being had to the objects of its creation.

"7. The first members of the Council shall be elected tonight and shall hold office as hereinbefore provided in part three.

"8. Vacancies in the Council shall be filled for the unexpired term by appointment of the president of the Association."

The plan under which the Council was to act having been gotten out of the way, a motion was entertained to the effect that the members of the Council for the ensuing year be voted upon. The following were elected as members of the Council for the ensuing year:

*Medical*.—Drs. Charles E. Sadtler, Wilmer Brinton, Harry Adler, B. Merrill Hopkinson, E. F. Cordell, Nathan Winslow.

*Pharmacy*.—John B. Thomas, Ph.G.; H. A. B. Dunning, Phar.D.; J. Emory Bond, Ph.G.; E. F. Kelly, Phar.D.; Charles Morgan, Ph.G.; C. L. Meyer, Ph.G.

*Academic*.—Drs. A. L. Wilkinson, J. Clement Clarke, J. D. Iglehart; E. J. W. Revell, LL.B.; W. I. Dawkins, LL.B.; H. H. McBride, B.A.

*Law*.—Gen. Lawrason Riggs, LL.B.; Samuel J. Harman, LL.B.; James W. Bowers, LL.B.; F. V. Rhodes, LL.B.; George Weems Williams, LL.B.; Lee S. Meyer, LL.B.

*Dental*.—Drs. Joseph G. Heuisler, L. Wilson Davis, Eldridge Baskin, S. Claude Sykes, W. G. Boyd, H. F. Gorgas.

The meeting then adjourned.

The formation of the Alumni Advisory Council marks an epoch in the internal management of the University of Maryland. Its possibilities for the upbuilding of the University and broadening its sphere are unlimited. It is certainly a move in the right direction and is only one of the many changes for the better which have occurred during the past decade.

The Alumni now have an official medium through which they may bring to the attention of the faculty their views, and we think that much benefit will accrue to the University as a result of its formation.

## ITEMS

Dr. Herbert Jerome Rosenberg, class of 1908, of Atlanta, Ga., who has been confined to the University Hospital for the past six weeks with rheumatism, has left for Mt. Clemens, Michigan,

where he will take the baths. We are pleased to report to his friends that Dr. Rosenberg leaves the hospital in a much improved condition.

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Dr. Marshall Langton Price, class of 1902, secretary of the State Board of Health, declared that if he had \$50,000,000 and autocratic power he could stamp the germs of tuberculosis and typhoid fever out of the State of Maryland. He was asked how he would go about it.

"It would first be necessary to change human nature," he said, "which would have to be accomplished gradually and systematically and by the application of drastic measures. It would be a comparatively easy task to eliminate the germs of tuberculosis from a herd of cattle, and practically the same measures would have to be adopted with human beings.

"The first step in this direction would be to make the tuberculin test to determine those affected. Next would come a segregation of the various classes—the infected and the uninjected. The establishment of segregation camps would come next, with drastic provisions made for confining patients therein."

"How would you prevent persons infected with the disease from entering the State?" was asked.

"Every train and vessel coming into the city would be inspected, and on a case being found it would be sent immediately to one of the detention camps. Those who had not the disease would be given passports, as would all others in the city who were found to be free from infection. These passports would have to be renewed every two years."

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Dr. John F. Hawkins, class of 1906, and Mrs. Hawkins are rejoicing over the birth of a daughter.

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Professor Dr. Franz Kuhl of Cassel, Germany, will visit American universities in the spring, especially such institutions where special laboratories for experimental medicine exist. He will visit Montreal, Toronto, Harvard, Yale, Cornell, Columbia University of New York, Princeton, Rockefeller Institute, New York, University of Pennsylvania in Philadelphia, Jefferson Medical College, Johns Hopkins University, University of Maryland, Carnegie Institution and George Washington University of Washington, the la-

boratories of the Department of Agriculture, University of Chicago and Western Reserve University at Cleveland, Ohio. While in Baltimore Dr. and Mrs. Kuhn will be guests of Professor and Mrs. John C. Hemmeter. Professor Kuhn is a noted thoracic surgeon and has performed many original operations on the respiratory passages by an original method of general anaesthesia and is the inventor of many new surgical appliances and instruments. He will give demonstrations at the University of Maryland in April.

We are sorry to report that Dr. George Mahle, class of 1905, is in such poor health that he has been forced to forego the practice of medicine.

Miss Clara Robinson, Training School for Nurses, class of 1907, is a patient in the University Hospital.

Dr. William Irvin Messick, class of 1895, has removed his office from 1606 Madison avenue to 1700 Linden avenue, corner of Wilson street, Baltimore, Md.

Dr. John C. Hemmeter, class of 1884, has been invited to deliver the annual address before the Pennsylvania Alumni of the University of Maryland at Harrisburg, Pa., February 23. He will speak on "The Biology of Genius."

Dr. Howard J. Maldies, class of 1903, is giving a course in bacteriology to the third year dental students.

Professor A. Bickel, director of the biologic department of the Institute of Pathology of the University of Berlin and editor of the *International Archives for Physiology of Digestion* and of the *Biochemische Zeitschrift*, has written to Dr. John C. Hemmeter, class of 1884, and requested him to become co-editor of these journals in place of Professor Christian A. Herter, deceased. Dr. Herter was a brilliant physiologic chemist and founder of the Herter lectureships at the Bellevue Hospital Medical College of New York and the Johns Hopkins University.

There will be a meeting of the Alumni Advisory Council for the purpose of organization on Tuesday afternoon, February 28, 1911, at 4 P. M.,

at the office of Mr. Walter I. Dawkins, 408 Fidelity Building, Baltimore, Md.

A doctor is very much needed at Davidsonville, Anne Arundel county, Maryland. For information write to Charles B. Townshend at the above address.

At the recent meeting of the American Laryngological, Rhinological and Otological Society, held at Piedmont Club, Lynchburg, Va., papers were read by the following University of Maryland men: Dr. Thomas Chew Worthington, class of 1876, on "Acute and Chronic Inflammation of the Maxillary Sinus, Its Recognition and Treatment," and by Dr. John R. Winslow, class of 1888, on "Report of Some Interesting Mastoid Cases."

Dr. Charles Franklin Strosnider, class of 1909, now located as assistant for Hookworm Disease, North Carolina Board of Health, is contributing a series of articles to the Goldsboro (North Carolina) Daily Argus.

Dr. Ralph Steiner, class of 1883, has been appointed health officer of Austin, Texas.

Dr. Cyril W. Fowble, class of 1910, is located at 2900 Parkwood avenue, Baltimore, Md.

Dr. William Quail Skilling, class of 1883, is located at Lonaconing, Md.

The General Alumni Association held on February 6 the theater party referred to in the last issue of the BULLETIN, which proved a huge success.

Of the membership of the Alumni Advisory Council, Dr. Wilmer Brinton, Dr. Charles Morgan, Messrs. S. J. Harman and George Weems Williams and General Lawrason Riggs were unable to accept the honor tendered them. Acceptances have been received from Drs. Herbert F. Gorgas, Joseph G. Henisler, J. Emory Bond, S. Wilson Davis, J. Clement Clark, C. E. Sadtler, B. Merrill Hopkinson, Eugene F. Cordell, Nathan Winslow, John B. Thomas, E. F. Kelly, J. D. Iglehart, J.

W. Holland, A. L. Wilkinson, Harry Adler, Eldridge Baskin, Charles L. Meyer, H. A. B. Dunning, and Messrs. Edgar H. McBride, James W. Bowers, W. I. Dawkins, F. V. Rhodes, Lee S. Meyer, S. Claude Sykes and E. J. W. Revell.

Dr. Joseph W. Holland was appointed vice Dr. Wilmer Brinton, resigned.

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Dr. Arthur M. Shipley, class of 1902, in remitting for tickets to the General Alumni Association's theater party, writes: "Here is a check for the tickets. I enjoyed the play and am glad I went. I am always glad to help in any way that I can any movement for the good of the University."

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### CORRESPONDENCE

The following are some of the views expressed by representative alumni concerning the Alumni Advisory Council:

"As I am always anxious to do whatever is in my power for the University of Maryland, I hasten to accept and assure you of my appreciation of the honor conferred upon me."—Harry Adler, M.D., class of 1895.

"I am in receipt of your letter of the 27th, and would say in reply that I feel highly honored by election to membership in the Council and will do all that I can to further the interests of the University."—Edgar H. McBride, A.B., St. John's, and also student Law Department, University of Maryland.

"It will give me pleasure to lend my aid in any way I can for this object. While I am some distance from the city, if you will notify me of the meetings, I will come when it is possible."—J. Clement Clark, M.D., class of 1880.

"I look upon this as a most important step in the future of the University of Maryland, and I am of the view that the members of this committee should be men who can give their time to this very important matter; indeed, they should be 'strenuous' in their efforts to improve the existing conditions at the University. I believe the move is a 'step in the right direction,' and I regret that I am not young and strenuous enough to engage in the good work."—Wilmer Brinton, M.D., class of 1876.

"I am pleased to accept the honor conferred on me by the Executive Committee of the General Alumni Association of the University of Mary-

land, and will be glad to serve on the Alumni Advisory Council."—Eldridge Baskin, D.D.S., class of 1903.

"In acknowledging your communication of 27th ult. would say I appreciate the honor, and will accept the duties involved in the membership in the Advisory Alumni Council of the University of Maryland."—S. Claude Sykes, D.D.S., class of 1890.

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### MARRIAGES

The marriage of Dr. John Watkins Williams, class of 1906, of Everett, N. C., to Miss Bertie Zenobia Gardner, daughter of Mr. and Mrs. Frederic Gardner of Williamston, N. C., took place at the Methodist Church of Williamston on Wednesday, January 18, 1911, at half-past four o'clock. The couple will reside in Everett.

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The marriage of Miss Mary Rebekah Woods, daughter of Dr. Hiram Woods, Jr., class of 1882, of Baltimore, to Mr. Alexander Armstrong of Hagerstown, Md., took place January 25, 1911, at First Presbyterian Church of Baltimore. The ceremony was performed by Rev. Arthur Chilton Powell, rector of Grace Protestant Episcopal Church, assisted by Rev. Dr. C. C. Woods of the Church of the Covenant, Washington.

The bride entered the church with her father, by whom she was given in marriage, and was met by the groom, attended by his best man, Mr. John Armstrong of New York. Miss Woods wore a white satin gown and rose point lace. Her tulle veil was caught with orange blossoms and she carried a shower of lilies-of-the-valley and gardenias. Her only ornament was a crescent of diamonds and pearls, the gift of the groom. She was attended by her sister, Miss Laura Hall Woods, as maid of honor, who wore pale yellow satin, veiled in chiffon, embroidered in pearls and gold beads, and carried an old-fashioned lace-frilled bouquet of yellow rosebuds.

The bridesmaids—Miss Powell Byrd of Gloucester, Va.; Miss Ann Bruin of Hagerstown and Miss Phyllis Stokes and Miss Virginia Woods—all wore gowns of pale blue satin, with tunics of crystal-studded net, with bolero jackets of blue satin embroidered in silver and crystal, and carried old-fashioned bouquets of pink rosebuds.

The ushers were Messrs. Rupert S. Holland.

Howard H. Yocom and Dr. Edward McPherson Armstrong of Philadelphia; Henry Garrison of Newark, N. J.; James W. Norris of New York, and Allan Churchill Woods of Baltimore.

## DEATHS

Dr. Reynaldo Dorsey Mackin, class of 1888, died at his home at Grafton, W. Va., January 30, 1911, of Bright's disease, aged 47 years. He was a native of Grafton, the son of the late William and Emily Mackin, pioneers of this place, who had come from Howard county, Md., in 1852, before Grafton was an incorporated town.

He was also a graduate of the Ohio Medical College of the class of 1887. Dr. Mackin was well known politically and served in the West Virginia Legislature as a Democrat. He was never married. Two sisters and two brothers, all of Grafton, survive him.

Dr. Thomas Harris Cannon, class of 1901, died at the University Hospital after a short illness January 29, 1911. Death was due to uremia.

Dr. Cannon was born in Baltimore, May 4. Dr. Cannon was born in Baltimore, May 4, 1878, the son of Thomas J. and Eleonora Saumenig more public schools and Deichmann's Preparatory School, and then entered the University of Maryland, graduating in 1901. He made special preparation in the field of electro-therapeutics and limited his practice to that department. In 1898 he received an appointment as hospital steward in the United States Army, serving for one year.

Dr. Cannon was a member of the American Medical Association and vice-president of the American Electro-Therapeutic Association, demonstrator in the clinical laboratory of the University of Maryland, physician to the Methodist Episcopal Home for the Aged, and surgeon to the Free Summer Excursion Society.

He married January 18, 1899, Miss Myrtle Evelyn Warner, who, with one daughter, Miss Eleanor Cannon, survives him. His mother, Mrs. Eleonora Cannon; his sister, Mrs. J. F. Phillips of Wilmington, Del., and one brother, Martin H. Cannon of Martinsburg, W. Va., also survive.

The funeral took place from his residence, 401 Fulton avenue, January 31, 1911. The services were conducted by Rev. Robert S. Coupland, rec-

tor of Ascension Protestant Episcopal Church, and Rev. Peter Ainslee of the Christian Temple and Rev. William H. Woods. The Masonic order took charge of the services at the grave in Loudon Park. The pall-bearers were fellow-members of his lodge of Masons.

## BOOK REVIEWS

**PRINCIPLES OF PUBLIC HEALTH.** A Simple Text-Book on Hygiene, Presenting the Principles Fundamental to the Conservation of Individual and Community Health. By Thomas D. Tuttle, B.S., M.D., Secretary and Executive Officer of the State Board of Health of Montana. Yonkers-on-Hudson, New York: World Publishing Co. 1910.

This book, containing the elements of hygiene, is, on the whole, reliable, and can be recommended to a certain clientele, namely, school children and lay readers not versed in the principles of hygiene. As a medical book for physicians it does not come up to the standard, and we feel sure the writer did not intend it to occupy a position as a medical work. If put in the hands of children much good might result in teaching them something of the magnitude of the problems concerning the maintaining of their bodies in a healthy state.

**PRIMER OF HYGIENE.** By John W. Ritchie, Professor of Biology, College of William and Mary, Virginia, and Joseph S. Caldwell, Professor of Biology, George Peabody College for Teachers, Tennessee. Yonkers-on-Hudson, New York: World Publishing Co. 1910.

This book tells in a simple way the proper methods to keep the body-health. It is written in a popular vein and is intended evidently for the mass. Generally speaking, the statements contained therein are accurate. It is replete with many useful suggestions, and is, therefore, an exceptionally good book for the laity. As a medical publication it is of little importance and does not meet the requirements of the medical reader. It is merely a nice little book on a subject concerning which the general public should be better posted and, as such, it comes up to all requirements.

# THE HOSPITAL BULLETIN

OF THE

# UNIVERSITY OF MARYLAND

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